

Bucks County Emergency Medical Services

EMERGENCY INCIDENT



OPERATING GUIDELINES

Bucks County Mass Casualty Committee
Of the
Bucks County Squad Chief's Association

Second Revision (Original – 1998)
Approved by the Bucks County Squad Chief's Association on January 17, 2006

Portions of this document used and modified with permission of:

- Eastern PA Emergency Medical Services Council
Disaster Operating Guidelines (July 1999)
- Montgomery County Emergency Services Council
Major Incident Response Plan (June 2001)

STATEMENT OF PURPOSE

These emergency incident-operating guidelines are designed to assist Bucks County Emergency Medical Services agencies in properly organizing and controlling resources at the scene of an emergency incident. These guidelines will serve as a basic framework upon which each local jurisdiction can, and should, build a more specific plan. Such a plan may address other areas of concern and use of resources not referenced to in this document. These guidelines are not intended to replace any established county, municipal or local emergency response plan. Rather, they are intended to serve as the central core for emergency medical services operations at an emergency incident.

These emergency incident-operating guidelines are also intended to identify the basic working relationships, which should exist between EMS, fire, rescue, police and other agencies at a large-scale incident. As such, these emergency incident-operating guidelines fully support and utilize the concept of a unified incident command system. It is strongly recommended that all Bucks County EMS organizations meet with their local emergency/public service agencies, municipal officials and county/local emergency management officials who might be involved in a large scale incident, to develop or review a specific emergency response plan for the community(s) they serve.

SCOPE

This document shall serve as the Emergency Incident Operating Guidelines for emergency medical services of the Bucks County Emergency Health Services Council. These guidelines will only address key elements of the EMS segment of an areas total emergency response plan, and how it operates within the unified command system.

OPERATIONAL METHOD

This document shall utilize the sector concept for EMS operations during an emergency response. The National Fire Service Incident Management Consortium defines a sector as, “A tactical level management unit having responsibility for either a geographical or functional assignment...” Beyond the EMS Commander and the EMS Operations Officer’s roles and responsibilities, the three sector’s identified within these guidelines are; Triage Sector, Treatment Sector and Transport Sector.

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Overview

Loss of property, loss of human life, a large number of injuries ranging from minor to life threatening, separation of family members and an overall disturbance of routine operating procedures characterize disasters.

The treatment and/or stabilization, extrication, transportation of the injured to appropriate medical facilities, rehabilitation of responding personnel, recognition and/or institution of critical incident stress management team, restoring and maintaining order and identifying the dead are common among the varied responsibilities which may be unexpectedly thrust upon emergency response organizations.

Disasters can occur in varying degrees, at any time, and in practically any conceivable situation. The potential categories for disasters in the Bucks County Region may include, but are not limited to:

- | | |
|---|-------------------------------------|
| a. Major Vehicular Accidents With Multiple Victims | e. Mining or Construction Accidents |
| b. Fires | f. Industrial Accidents |
| c. Environmental/Natural Disasters | g. Building Collapses |
| d. Public Transportation Accidents (Aircraft, Train, Bus) | h. Terrorism Incidents |

All disasters present several diverse and unique problems requiring prompt and efficient management. In order to identify the roles and responsibilities for emergency response personnel expected to handle initial triage and patient care at a disaster scene, a preconceived plan of action must exist. The plan requires the participation and cooperation of local agencies, such as, but not limited to:

- | | |
|-----------------------------|---|
| a. Law Enforcement Agencies | g. County Coroner |
| b. Fire Departments | h. Ancillary Volunteer Agencies (i.e. American Red Cross) |
| c. EMS Services | I. Emergency Management Agencies |
| d. Rescue Services | j. Governmental Agencies |
| e. Hospitals | k. CISM Teams |
| f. Haz Mat Team | |

Specific responsibilities must be assigned to each participating agency. Job assignments should include written descriptions with duties and responsibilities clearly defined. The usual everyday responsibilities of the individuals and agencies involved will, by necessity, change to be able to handle the new priorities created by the disaster.

THE PRIMARY CONCERN OF ALL EMERGENCY RESPONSE OPERATIONS MUST BE TO SAVE AS MANY LIVES AS POSSIBLE WITH THE RESOURCES WHICH ARE AVAILABLE. In certain cases such as floods, hurricanes and tornadoes that have been forecast by the weather bureau, rescue and evacuation operations may begin before the natural disaster actually strikes. This will occur by agencies being alerted to bring their immediate manpower needs up to operational levels. The success of any operation will be enhanced by an effective alerting, response and management system, which has been planned in advance.

SEQUENCE OF DESIRED EVENTS AT A MASS CASUALTY INCIDENT

- Preparation and mitigation.
- Pre-planning and education.
- Activation of the emergency plan, to include early warning, notification and preparation for potential disasters, which may involve multiple patients.
- Concise response system implemented. **First arriving police, fire and EMS units implement a unified command system.**
 - A Unified Command Post should be established and its location transmitted to responding emergency units by their communications center prior to their arrival at the scene. This notification may be made through the use of a special radio alert tone and announcement as to the initiation and location of the unified command post.
 - The Unified Command Post is a joint effort between the principal command personnel of all emergency service agencies represented at the scene and is to serve as the central base of operations at the disaster scene. Therefore, key officials, (i.e., Fire, Police, EMS, Municipal Officials, EMA Officials, Federal Investigators, Building Owners, etc.), should be directed to the Unified Command Post upon their arrival at the scene.
 - The Unified Command Post should be identified by the display of a GREEN means of identification that is visible from all sides of the stationary Unified Command Post, so that it is easily identified at the scene. For example, a green Unified Command Post sign, flag or light might be used to make this designation.
 - The secondary response is that which occurs after the arrival of the units first dispatched and the establishment of an on-scene Unified Command Post. Response during this phase of operations must be carefully controlled, with responding agencies respecting the authority and directives of the on-scene commanders. Emergency team responses should be to designated areas and not to the actual victim locations, unless otherwise specified by the on-scene commanders. If numerous emergency vehicles respond to actual victim locations against the direction of the Command Post, area congestion will become a major problem.
- First EMS personnel at the scene perform a primary survival scan, size-up of the incident scene and identify the EMS Commander.
 - Initial Triage consists of an initial “walk through” by the Triage Officer and first arriving emergency care personnel so that an approximate patient count can be determined and patients tagged according to the apparent severity of their injuries. The Triage Officer must quickly present a report on the patient count and approximate number of patients in each category to the EMS Commander.
- Initiation of critical life-saving treatment techniques during the rapid initial survey performed by the first arriving EMS personnel. (ABC's)
- Notification of **EXTENT** and **NUMBER OF CASUALTIES** to the communications center by the EMS Commander. The Communications center then notifies all agencies involved.
- Activation of area hospital disaster plans for external disasters according to the level of disaster that has been reported and the number of patients each facility may receive. **Notification to be made by the Bucks County Department of Communications.**

DISASTER LEVELS

- Level 1 Mass casualty situation resulting in greater than 10-24 surviving victims.
- Level 2 Mass casualty situation resulting in greater than 25-39 surviving victims.
- Level 3 Mass casualty situation resulting in greater than 40 surviving victims.

Patients tagged according to appropriate priorities by assigned Triage Team.

- All patients found to be “Dead-On-Arrival” should be left where they were found, if possible, until the Coroner and other appropriate officials confirm their disposition and complete their initial investigation of the incident. The deceased patients can be covered as long as the scene integrity will not be destroyed. If it becomes necessary to move a deceased victim in order to access or treat remaining victims, then the location and position that the deceased was found in must be noted in order to assist in identification and further investigation. A temporary morgue can be established in an area isolated from the patient care areas, if necessary.

Patients immobilized rapidly on portable transportation devices.

Casualty Collection Area established in well-marked areas by the Treatment Officer.

- The Casualty Collection Area should be divided into three separate sections, color coded by some means to match the triage tags:

Red	1st Priority
Yellow	2nd Priority
Green	3rd Priority

- Each section should allow sufficient space to enable emergency personnel to move around freely and treat multiple patients simultaneously without causing interference to one another. This will also allow for the easy removal of selected patients by transport personnel once at-scene patient care is completed and the patients are ready to be moved to an EMS transport vehicle.
- An area adjacent to the patient collection stations should be established for those “patients” that have been involved in a disaster but have sustained no injuries. Non-injured individuals that subsequently complain of injuries or illness may be re-triaged and moved to the appropriate patient collection station.

Patients delivered (by priority if possible) to Casualty Collection Area.

Patients arranged by priority at Casualty Collection Area.

Incoming emergency units report to Vehicle Staging Area designated by the EMS Commander, and drop off personnel and requested supplies / equipment. The driver must remain with the vehicle, awaiting further assignment.

Patient treatment implemented at Casualty Collection Area.

Advanced life support personnel and/or designated physician disaster response teams treat patients most in need of advanced care at Casualty Collection Area.

Patients transported in priority sequence, if possible, to designated hospitals as assigned by Transportation Officer. **In a Mass Casualty Incident, several patients SHOULD be transported in each vehicle in order to maximize the transportation resources that are available. EMS units should not be allowed to leave the incident scene with only 1 patient on-board.**

- The Transport Sector Officer, in conjunction with the Treatment Sector Officer, will oversee the selection of patients to be transported from the designated Casualty Collection Area to EMS transport vehicles from an established Vehicle Staging Area. The Transport Sector Officer will also decide the hospital to which each patient is to be transported to and will maintain a log of patient flow. It is therefore extremely important that the three separate patient collection areas be maintained to ensure that the Transport Sector Officer will have the means to make logical and concise decisions for transportation patterns. This saves time and lives.

Establish post incident equipment collection site.

Equipment and supplies returned to agencies involved.

CISD services made available.

Demobilization of personnel and units.

Preparation and pre-planning for long term operations.

Plan deactivated.

Reports and records assembled by Incident Commander

Post incident review of disaster scene operations conducted by all agencies involved, shortly after the incident.

Review and update of plan.

Command Structure at Multiple / Mass Casualty Incidents

It is the recommended that emergency services within Bucks County utilize a unified command structure when mitigating a multiple / mass casualty incident. The use of the unified command system is beneficial for the following reasons:

- It is more common, used by most responder agencies nationally.
- It is flexible and can expand or contract with the escalation and de-escalation of the incident.
- It is ideal for large scale or potentially large-scale incidents in the same jurisdiction, as well as in situations where there are multiple agencies from different jurisdictions involved in the incident management.
- It works well if the incident is large enough or located such that it covers multiple jurisdictions.

On scene operations are usually orchestrated by the agency having the most involvement **IF** that agency has the resources for the type of incident that is encountered. The unified command structure more easily supports the integration of non-public safety agencies into the incident management scheme than does the single command structure. It allows all agencies to participate in the development of the overall incident management objectives and selection of strategies to be employed in the mitigation of the incident. It also insures integration and consolidation of action plans and maximizes the use of resources.

The unified command structure also plays an important role in managing the “span of control” for personnel that are operating on an incident. It assists those that have experience in managing large-scale incidents as well as those who do not commonly manage large-scale incidents. This “span of control” is vital to the success of a large-scale incident.

- A manageable span of control should be kept at between 3 to 7 people, with an optimum number of 5 people.
- As a general rule, each person in the structure should have between 3 to 7 people, with an optimum number of 5 people, reporting to him/her.

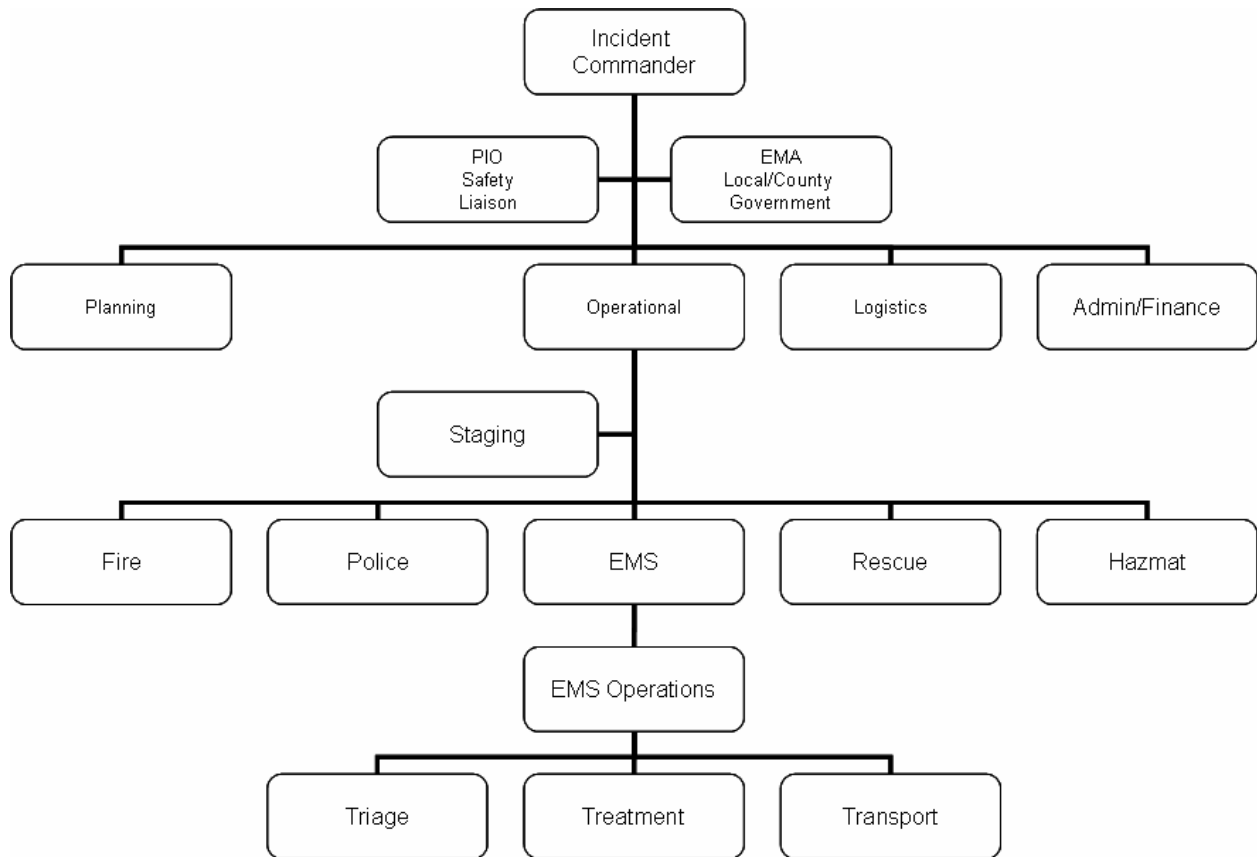
As the incident escalates, the lines of responsibility can be expanded and enlarged. Conversely, as the incident de-escalates and there is a demobilization of resources, the system can be downsized to meet the needs of the incident size at that time, right down to termination of the entire incident.

The unified command structure affords the ability for relief or change in command during large scale or extended incidents that go beyond regular or customary shift or work patterns. Finally, the unified command structure easily adapts to written forms of communications and planning where mitigation plans may need to be approved in writing. (Although this is not customary in the EMS component, it is common place in fire or hazardous materials incidents).

The organizational charts that follow are a typical representation of the command structure that would be employed under the unified command system. EMS agencies within Bucks County are strongly encouraged to utilize the unified command structure in their planning and response to multiple / mass casualty incidents.

Please note that the terms Triage Officer, Treatment Officer and Transport Officer are all used interchangeably with the terms Triage Sector Officer, Treatment Sector Officer and Transport Sector Officer. These terms refer to the same individual.

UNIFIED INCIDENT COMMAND STRUCTURE



INCIDENT COMMANDER: The individual in overall command of an emergency incident.

PIO (public information officer): The individual that is responsible for the release of information about the incident to the news media and other appropriate agencies and organizations.

SAFETY: The individual that is responsible for monitoring and assessing hazardous and unsafe situations and developing measures for assuring personnel safety.

LIAISON: The individual that is responsible for interacting, (by providing a point of contact), with the other agencies and organizations involved in a disaster.

EMERGENCY MGMT. / LOCAL COUNTY GOVERNMENT: Individuals from these agencies that might have a role in the mitigation of a mass / multiple casualty incident. May serve as overall incident commander.

PLANNING: Responsible for the collection, evaluation, dissemination and use of information regarding the development of the incident and status of resources.

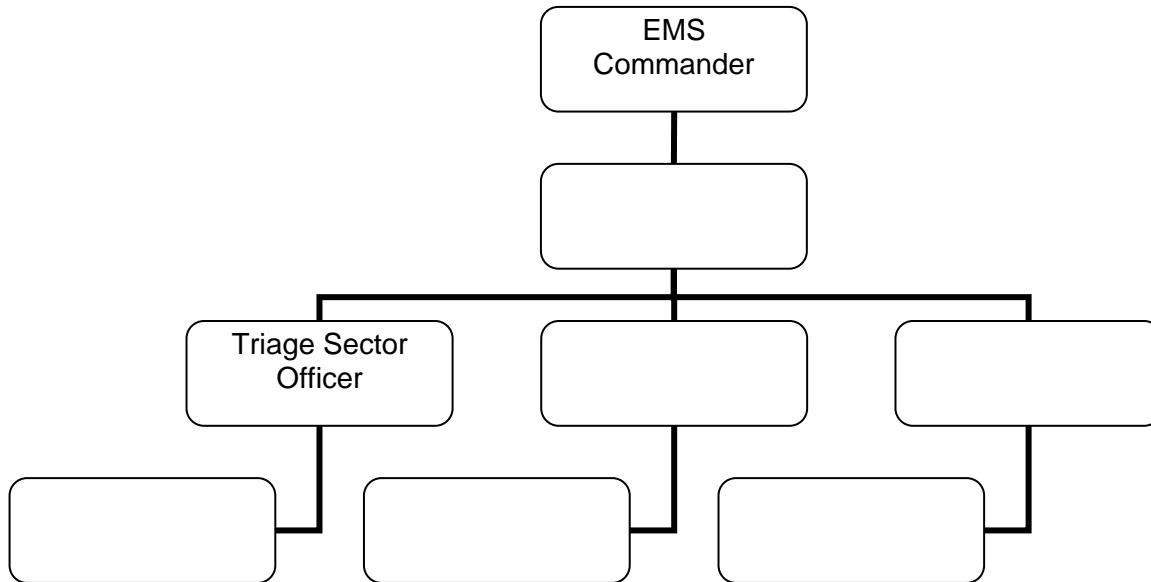
OPERATIONAL: Responsible for the management of all operations directly applicable to the primary mission.

LOGISTICS: Responsible for providing facilities, services and materials in support of the incident.

ADMIN. / FINANCE: Responsible to organize and operate the finance section within the guidelines, policy and constraints established by the incident commander and the responsible agency.

EMS Operations Structure Within the Unified Command System

NORMAL RESPONSE, 10 VICTIMS OR LESS



EMS (COMMANDER)- The individual that is responsible for the overall coordination of all EMS activities at a disaster scene. This individual should be located at the unified command post and coordinates EMS activities with the overall Incident Commander.

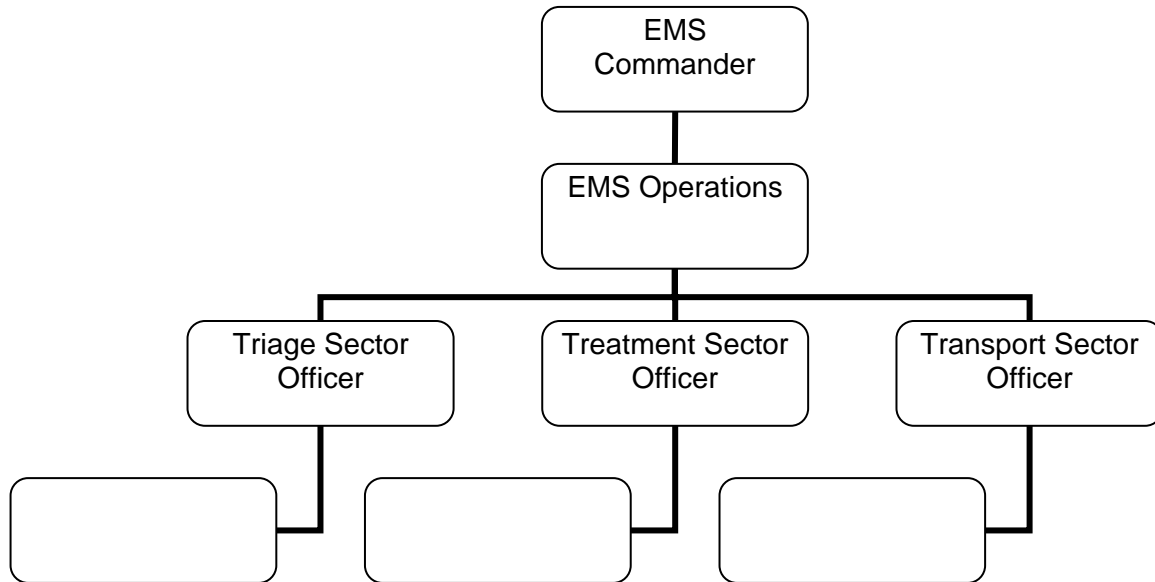
- In a routine response the EMS Commander should also be able to perform the duties normally assigned to the EMS Operations Officer and the Transportation Sector Officer.

TRIAGE OFFICER- The individual that is responsible for the overall coordination of triage activities at a disaster scene. Answers to the EMS Commander.

- In a routine response the Triage Sector Officer should also be able to perform the duties normally assigned to the Treatment Sector Officer.

EMS Operations Structure Within the Unified Command System

LEVEL 1 RESPONSE, 10 to 24 VICTIMS



EMS (COMMANDER)- The individual that is responsible for the overall coordination of all EMS activities at a disaster scene. This individual should be located at the unified command post and coordinates EMS activities with the overall Incident Commander.

EMS OPERATIONS OFFICER- The individual that is responsible for the coordination and management of EMS related resources at the incident site and acts as a liaison between the EMS Commander and EMS providers. Answers to the EMS Commander.

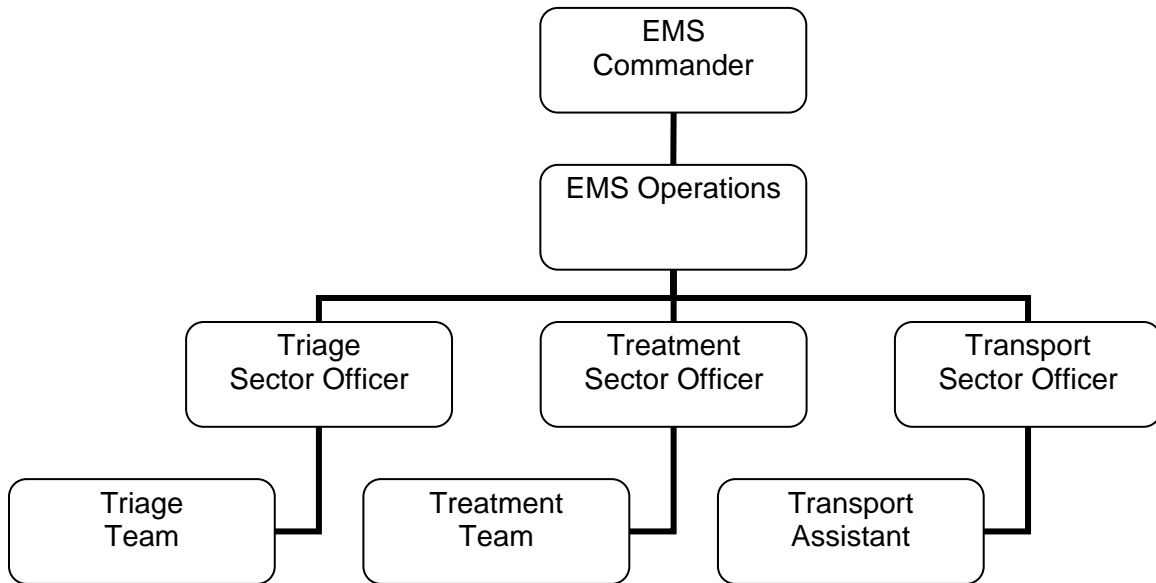
TRIAGE OFFICER- The individual that is responsible for the overall coordination of triage activities at a disaster scene. Answers to the EMS Commander.

TREATMENT OFFICER- The individual that is responsible for the coordination of the treatment of patients at the Casualty Collection Area. Answers to the EMS Commander.

TRANSPORT OFFICER- The individual that is responsible for communicating with sector officers and hospitals to manage the transport of patients to hospitals from the scene of the disaster. Answers to the EMS Commander.

EMS Operations Structure Within the Unified Command System

LEVEL 2 RESPONSE, 25-39 VICTIMS



EMS (COMMANDER)- The individual that is responsible for the overall coordination of all EMS activities at a disaster scene. This individual should be located at the unified command post and coordinates EMS activities with the overall Incident Commander.

EMS OPERATIONS OFFICER- The individual that is responsible for the coordination and management of EMS related resources at the incident site and acts as a liaison between the EMS Commander and EMS providers. Answers to the EMS Commander.

TRIAGE OFFICER- The individual that is responsible for the overall coordination of triage activities at a disaster scene. Answers to the EMS Commander.

- **Triage Teams:** Groups of medically trained personnel that assist the Triage Sector Officer in the triaging of victims.

TREATMENT OFFICER- The individual that is responsible for the coordination of the treatment of patients at the patient collection stations. Answers to the EMS Commander.

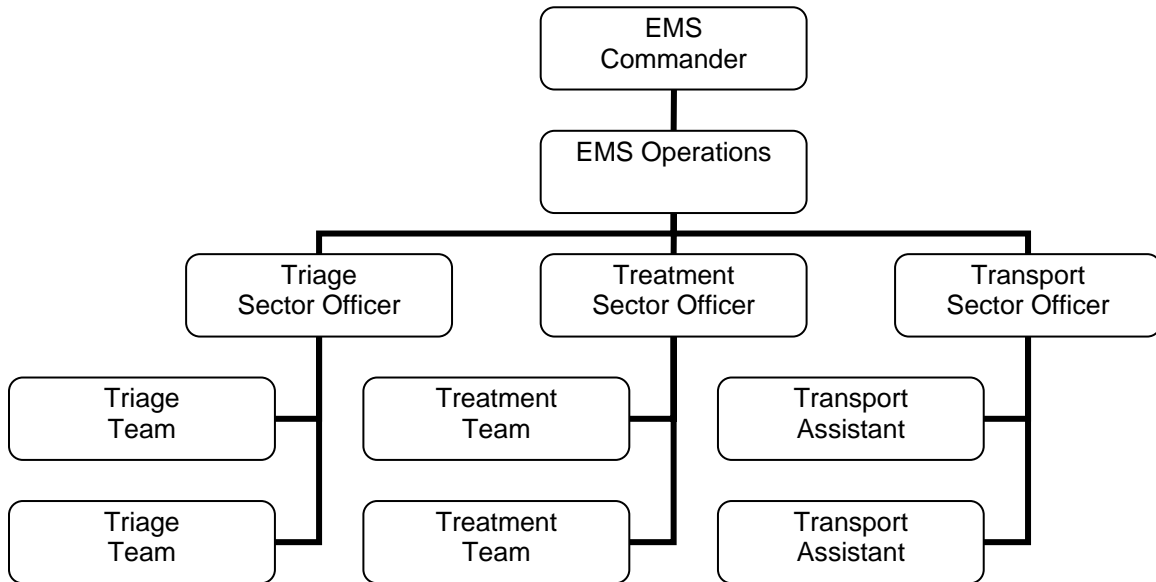
- **Treatment Teams:** Groups of medically trained personnel, including physicians and nurses that assist the Treatment Sector Officer with the treatment of victims brought to the Casualty Collection Area.

TRANSPORT OFFICER- The individual that is responsible for communicating with sector officers and hospitals to manage the transport of patients to hospitals from the scene of the disaster. Answers to the EMS Commander.

- **Transport Assistant:** An individual that assists the Transportation Sector Officer in the performance of his/her duties.

EMS Operations Structure Within the Unified Command System

*LEVEL 3 RESPONSE, GREATER THAN 40 PATIENTS



EMS (COMMANDER)- The individual that is responsible for the overall coordination of all EMS activities at a disaster scene. This individual should be located at the unified command post and coordinates EMS activities with the overall Incident Commander.

EMS OPERATIONS OFFICER- The individual that is responsible for the coordination and management of EMS related resources at the incident site and acts as a liaison between the EMS Commander and EMS providers. Answers to the EMS Commander.

TRIAGE OFFICER- The individual that is responsible for the overall coordination of triage activities at a disaster scene. Answers to the EMS Commander.

- **Triage Teams:** Groups of medically trained personnel that assist the Triage Sector Officer in the triaging of victims. As the Level of the incident escalates, more teams may be needed

TREATMENT OFFICER- The individual that is responsible for the coordination of the treatment of patients at the Casualty Collection Area. Answers to the EMS Commander.

- **Treatment Teams:** Groups of medically trained personnel, including physicians and nurses that assist the Treatment Sector Officer with the treatment of victims brought to the Casualty Collection Area. As the Level of the incident escalates, more teams may be needed.

TRANSPORT OFFICER- The individual that is responsible for communicating with sector officers and hospitals to manage the transport of patients to hospitals from the scene of the disaster. Answers to the EMS Commander.

- **Transport Assistant:** An individual that assists the Transportation Sector Officer in the performance of his/her duties. As the Level of the incident escalates, more assistants may be needed.

EMS COMMANDER

The EMS Commander is responsible for the overall coordination of EMS activities at the emergency incident site. These duties shall include:

1. Establishing and identifying a location for the unified command post **if this has not already been accomplished by other emergency personnel**. The location of such a command post must be transmitted to the communications center for relay to other responding emergency services, (e.g., police, fire, haz-mat). Such a relay of information may be made by a special radio alert tone and announcement of the initiation of a unified command post and its' location.
2. Rapidly assess the scope of the disaster incident, paying particular attention to the following
 - the nature of the incident.
 - any hazards that are present.
 - number of casualties.
 - types and extent of injuries including a rough estimate of the number of casualties present.
 - additional resources that may be required at the scene.
 - responding unit's route of approach to the scene.
 - location(s) for potential staging area(s).
3. Transmit a preliminary report to the communications center for relay to other responding emergency services.
4. Transmit a preliminary report to the communications center so that initial notification of the existence of a mass casualty incident can be made to area hospitals. (Further information as to number and extent of injuries, hospital resources available, etc., can be made as the incident progresses).
5. Establish an EMS communications structure for the disaster scene. This structure may later be relocated to a specialty vehicle, if one is available.
6. Determine if additional response, including the mobilization of regional mass casualty equipment caches, is required at the incident.
7. Assign Sector Officers:
 - Operations Officer
 - Triage Sector
 - Treatment Sector
 - Transportation Sector

Note: It may be necessary to combine the roles of Sector Officers until sufficient manpower is available to fill these positions. Also, dependent upon the "size" of the incident, it may be possible to combine the roles of Sector Officers.
8. Assign medical teams to the Triage or Treatment Sector's, based on the needs of those sectors.
9. Work in conjunction with the Fire/Rescue Officials to assign crews to carry and transfer patients to the Casualty Collection Area(s).
10. *Consult with Sector Officers frequently to ascertain the need for additional resources and the safety and well being of all EMS personnel operating at the incident, (to include the provision of rehab and CISM services if necessary).
11. Establish liaisons with other emergency services agencies operating at the incident.
12. *Evaluate the effectiveness of EMS operations and make changes as required and necessary.
13. Transmit periodic progress reports on EMS Operations to the communications center.

14. *Re-assign EMS personnel / units as EMS operations de-escalate.
15. If necessary, establish a temporary morgue location and coordinate the management of fatalities with the Triage Sector Officer and Coroner of jurisdiction..
16. *Maintain documentation as to the overall provision of EMS operations at the incident.
17. *De-mobilize and terminate EMS operations, including the cessation of EMS command operations.

*** In conjunction with the EMS Operations Officer in a level 1, 2, 3**

EMS COMMAND CHECKLIST

PERSONNEL ASSIGNED: Highest-ranking EMS provider, chief officer or other designated officer.

FUNCTIONS: Command and control of all EMS activities at a multiple casualty incident.

DUTIES:

- Don appropriate identification article, **BLUE** in color and appropriately labeled “**EMS COMMAND**”.
- Assess situation:
 - Type of Incident:**
 - Number of Victims:**
 - Disaster Level:**
 - Notify Bucks County Radio Room:**
 - Notify Local Communications Center(s):**
 - Notify Local Hospitals:**
- If not already performed, identify location for unified command post. If a Unified Command Post already exists, identify self to the Incident Commander and maintain position at the Unified Command Post.
- Appoint other EMS Officer duties as needed by scope of the incident:
 - Operations Officer:**
 - Triage Officer**
 - Treatment Officer**
 - Transport Officer:**
- Identify Staging Area.
- Request additional ambulances.
- Request additional EMS resources as necessary (I.E Mass Casualty Units or manpower).
- Establish medical communications network. “Clear text” is to be utilized for radio communications. This will reduce the confusion that can exist when radio codes are used, particularly when different agencies work together at a major incident:
 - Freq. to Command:**
 - Freq. to Triage Officer**
 - Freq. to Treatment Officer:**
 - Freq. to Transport Officer:**
 - Freq. to Hospitals:**
 - Freq. to Local Communications Center(s):**

- Assign manpower/resources to EMS area as needed and requested by Sector Officers.
- Request Law Enforcement for scene security.
- Notify Coroner of jurisdiction, if necessary.
- Provide regular updates and reports of EMS operations to the Incident Commander.
- Maintain Records.

EMS OPERATIONS OFFICER (as designated by the EMS Commander)

The EMS Operations Officer is directly responsible to the EMS Commander for the coordination and management of EMS related resources at the incident site. Designated by the EMS Commander at a Level 1 response and above, the EMS Operations Officer acts as a liaison between the EMS Commander and other Sector Officers / EMS providers that are operating at the scene. These duties shall include:

1. Allocating available resources to each sector of EMS operations as needed.
2. Frequent consultation with other Sector Officers to ascertain the need for additional resources and the safety and well being of all EMS personnel operating at the incident. This shall include ensuring the provision of rehab and CISM services, if necessary.
3. The tracking of available units on location and the availability of other resources within the EMS system.
4. In coordination with the Transport Sector Officer, the tracking and distribution of priority 1, 2 and 3 patients, in relation to the number of patients each facility is able to receive.
5. Evaluating the effectiveness of EMS Operations and suggesting changes as deemed necessary.
6. Controlling bi-directional communications between other sectors and the EMS Commander in order to allow a free flow of information to and from the scene.
7. Coordinating the distribution of mutual aid resources throughout the EMS system in order to ensure that system integrity is maintained within the affected area.
8. Re-assigning EMS personnel and units as EMS Operations de-escalate.
9. Maintaining documentation as to the overall provision of EMS at the incident
10. In coordination with the EMS Commander, demobilization and termination of EMS Operations at the incident site.

EMS OPERATIONS OFFICER CHECKLIST

PERSONNEL ASSIGNED: EMT, paramedic or other designated personnel as assigned by the EMS Commander.

FUNCTIONS: Responsible for the coordination and management of EMS related resources at a multiple casualty incident. The Operations Officer acts as a liaison between the EMS Commander and other EMS providers on location.

DUTIES:

- Don appropriate identification article, appropriately labeled “**EMS Operations**”.
- Obtain situation briefing from EMS Commander:
 - Type of Incident:**
 - Number of Victims:**
 - Disaster Level:**
- Verify Sector Officer assignments
 - Triage Sector Officer:**
 - Treatment Sector Officer:**
 - Transport Sector Officer:**
- Verify medical communications network:
 - Freq. to Command:**
 - Freq. to Triage Officer:**
 - Freq. to Treatment Officer:**
 - Freq. to Transport Officer:**
 - Freq. to Hospitals:**
- Verify location(s) of staging area(s).
- Allocate available resources to Sector’s as needed.
- Consult with Sector Officers frequently to ascertain the need for additional resources and the safety and well being of EMS personnel, (including the availability or need for rehab and CISM services).
- Coordinate with the Transport Sector Officer the patient distribution to medical facilities based on the number of patients the facility is willing and/or able to accept.
- Verify with the communications center the distribution of EMS mutual aid
- Keep EMS Command informed / updated on EMS operations.
- Evaluate the effectiveness of EMS operations and make changes as required.
- Re-assign EMS personnel / units as EMS operations de-escalate.
- In coordination with the EMS Commander, de-mobilize and terminate EMS operations at the incident.
- Maintain documentation as to the overall provision of EMS at the incident and forward reports / records to the EMS Commander.

TRIAGE SECTOR OFFICER (as designated by the EMS Commander)

The Triage Sector Officer is directly responsible to the EMS Commander for the coordination of triage operations at the disaster site. These duties shall include:

1. Assigning medically trained personnel to assist in carrying out the triage of patients, to include the proper tagging of patients based upon their condition and the administration of basic care that would correct immediate life-threatening problems, (e.g., airway problems or severe bleeding).
 - Triage normally occurs at the immediate site, or impact area, of the incident. However, safety concerns for the patients and medical personnel may force triage to be performed in an area adjacent to this site or at the Casualty Collection Area. Should this be the case, coordination with the Treatment Sector and EMS Commander is imperative.
 - Assess possible need for decontamination.
2. Obtaining an actual total victim count and an approximate victim count for each triage priority category. This information shall be immediately communicated to the EMS Commander and/or the EMS Operations Officer.
3. Ensuring that an adequate number of personnel and equipment is available for the triage and primary treatment of patients. Personnel and equipment needs shall be communicated to the EMS Commander and/or the EMS Operations Officer.
4. Ensuring that an adequate number of personnel and equipment is available to remove patients from the triage sector to the Casualty Collection Area. Personnel and equipment needs shall be communicated to the EMS Commander.
5. Coordinating operations within the Triage Sector with other sector officers and command, as needed.
6. Maintaining documentation as to the operations within the Triage Sector.
7. Providing the EMS Commander and/or EMS Operations Officer with updates as to the operations within the Triage Sector. This shall include timely notification to the EMS Commander when all of the patients have been triaged and moved to the Patient Collection Stations.
8. Coordinating with the EMS Commander and the Coroner of jurisdiction, the management of fatalities. This may include the designation of a temporary morgue location.
9. Terminating, with consensus from the EMS Commander and/or the EMS Operations Officer operations within the Triage Sector and re-assigning personnel as directed by the EMS Commander.

TRIAGE OFFICER CHECKLIST

PERSONNEL ASSIGNED: EMT, paramedic or other designated officer as assigned by the EMS Commander.

FUNCTION: Coordinate and direct the triage and tagging of victims of a multiple casualty incident.

DUTIES:

- Don appropriate identification article, labeled “**TRIAGE OFFICER**”.
- Read duty check sheet.
- Obtain situation briefing from EMS Command.
- Verify medical communications network
 - Freq. to Command:**
 - Freq. to EMS Operations Officer:**
 - Freq. to Treatment Officer:**
 - Freq. to Transport:**
- Obtain an actual victim count and an approximate count for each triage priority category and communicate this information to the EMS Commander and/or EMS Operations Officer.
- Assign medically trained personnel to assist in carrying out the triage of patients, to include proper tagging based upon condition and the administration of basic life-saving care.
- Ensure that an adequate amount of personnel and supplies are available for the primary triage and treatment of patients. Communicate personnel and equipment needs to the EMS Commander and/or EMS Operations Officer.
 - Rule of Thumb: 2 personnel for every 10 victims.
- Ensure that an adequate number of personnel and equipment is available to remove patients from the Triage Sector to the Casualty Collection Area. Communicate personnel and equipment needs to the EMS Commander and/or EMS Operations Officer.
- Coordinate interaction between triage teams and extrication teams with the incident Rescue Officer.
- Assume function of Treatment Officer until position is appointed by the EMS Commander.
- Assign re-triage team(s) at the entrance to the Casualty Collection Area(s).
- Keep Transport Officer informed of the number of victims and their triage priority.
- Keep EMS Command and/or the EMS Operations Officer informed of operations in the Triage Sector, to include timely notification when all patients have been triaged and moved to the Casualty Collection Area.
- Coordinate with the EMS Commander and the Coroner of jurisdiction, the location of a temporary morgue, (if needed).
 - Document, and if possible, mark the location of remains that had to be moved to effect the extrication, treatment and removal of survivors.

- Assign morgue manager.
- Assure area security.
- Assign personnel as needed.
- Verify with the Treatment and Transport Officer's the final number of victims in order to accurately determine that all victims have been accounted for, treated and transported from the scene.
- Maintain documentation as to operations conducted within the Triage Sector.
- Terminate, with consensus from the EMS Commander, and/or EMS Operations Officer, operations within the Triage Sector, and re-assign personnel as directed..

TRIAGE TEAM MEMBER CHECKLIST

PERSONNEL ASSIGNED: First Responder, EMT, paramedic or other medically trained personnel as designated by the Triage Officer.

FUNCTION: Responsible for assisting in the initial triage evaluation and priority designation of victims of a multiple casualty incident.

DUTIES:

- Secure sufficient number of triage tags and strings.
- Secure proper pen or pencil to mark major injuries on triage tags.
- During the triage process, provide only basic care that would correct immediate life-threatening problems, e.g. airway problem or severe bleeding).
- Secure triage tags loosely around patient's neck.
- Report total number of victims triaged and their priority category to the Triage Officer.
- Report any problems or special situations encountered to the Triage Officer.
- Report to Triage Officer when assignment is complete.
- If assigned to the re-triage area at the Casualty Collection Area
 - Assure that patients entering the Casualty Collection Area(s) have been triaged and that the triage tags have been placed correctly.
 - Verify that the patient priority is consistent with their injuries and re-prioritize if necessary.
 - Assist with the monitoring and re-triage of patients already within the Casualty Collection Area.
- As necessary, forward reports and updates to the Triage Officer.

TRIAGE / TAGGING GUIDELINES

INITIAL TRIAGE AND DISASTER TAGGING GUIDELINES

The initial triage is based upon accepted triage procedures and in accordance with the patient triage tags.

Prioritization of disaster victims differs somewhat from the routine classification of patients, e.g., a patient normally classed as a "Category 1" due to severe burns will be tagged as a 2nd priority patient, (yellow tag), at a disaster scene unless there is respiratory tract involvement.

Depending on the scope of the disaster, the total number of patients in need of care, and resources available to handle the victims, some patients with severe injuries which may not allow them to survive unless they are given immediate, intensified care, may have to be assigned lower priority "tags" for treatment/transport from the incident site. (Remember: your objective is to save as many patients as possible with the resources available).

A. UNINJURED / WHITE TAG

Individuals that have been involved in the disaster but are uninjured.

B. FIRST PRIORITY / RED TAG

The patient's chance for survival depends on prompt care.

- Uncorrected Respiratory Problems (NOT mild respiratory distress).
- Severe or Uncontrollable Bleeding (includes suspected internal bleeding).
- Severe Shock
- Open Chest or Abdominal Wounds.
- Unconscious Patients.
- Burns Involving the Respiratory Tract.
- Severe Medical Problems.
 - Heart attack
 - Poisoning
 - Diabetes with complications
 - Abnormal childbirth situation (prolapsed cord, arm or leg presentation)
 - Loss of distal pulse in an extremity
- Several Major Fractures, e.g. pelvis and femur).
- Serious injury/fatality of an emergency services co-worker
- Uncontrolled Emotional Disorders

C. SECOND PRIORITY / YELLOW TAG

Serious, but can be delayed while First Priority cases are handled.

- Severe Burns (not affecting airway)
- Spinal Injuries
- Moderate Blood Loss
- Conscious with Head Injuries

D. THIRD PRIORITY / GREEN TAG

Can wait for treatment until higher priorities are cared for.

- Minor Fractures
- Minor Injuries That Are Controlled
- Obviously mortal wounds where death appears reasonably certain. (These can be re-triaged later if personnel and/or resources become available).

E. DECEASED / BLACK TAG

Obviously dead (D.O.A.)

TREATMENT SECTOR OFFICER (designated by the EMS Commander)

The Treatment Sector Officer is directly responsible to the EMS Commander for coordinating the treatment of victims at patient collection stations. These duties shall include:

1. Establishing and identifying Casualty Collection Areas and communicating their location to the EMS Commander and/or the EMS Operations Officer.
 - This area must be large enough to accommodate the anticipated number of patients that could be received.
 - This area should be marked, by flags or markers color coded to match the patient triage tag, (Red - immediate, Yellow - moderate, Green - delayed).
2. Establishing an area adjacent to the Casualty Collection Areas for those individuals that have been involved in an incident but have sustained no apparent injuries. Non-injured individuals that subsequently complain of injuries or illness may be re-triaged and moved to the appropriate Casualty Collection Area.
3. Ensuring that an adequate amount of equipment, supplies and medically trained personnel, both BLS and ALS, are available at the Casualty Collection Area to provide appropriate treatment for all patients. Equipment, supplies and personnel needs shall be communicated to the EMS Commander and/or the EMS Operations Officer.
4. Ensuring that patients arriving at the Casualty Collection Areas have been triaged and that they are separated by priority. Non-triaged patients must be assessed and tagged before being moved to the appropriate Casualty Collection Area.
 - Remember, when placing patients in the Casualty Collection Areas, adequate space must be provided between patients to allow working room for medical personnel.
5. Ensuring that all patients receive treatment that is appropriate for their condition and that is within established state and regional medical protocols.
6. Coordinating the activities of ALL medical personnel in the Treatment Sector, (physicians, nurses, flight team members, etc.).
7. Ensuring the continual assessment and, where necessary, re-triaging of patients within the Casualty Collection Areas.
8. Determining the transport priorities of patients within the Casualty Collection Areas and coordinating their movement with the Transportation Officer.
9. Coordinating operations within the Treatment Sector with other sector officers and command, as needed.
10. Maintaining documentation as to the operations within the Casualty Collection Areas.
11. Providing the EMS Commander and/or the EMS Operations Officer with updates as to the operations within the Casualty Collection Areas. This shall include timely notification as to when all of the patients have been transported from the Casualty Collection Area
12. Terminating, with consensus from the EMS Commander and/or the EMS Operations Officer, operations within the Casualty Collection Areas and re-assigning personnel as directed.

TREATMENT OFFICER CHECK SHEET

PERSONNEL ASSIGNED: EMT, paramedic or other medically trained personnel as assigned by the EMS Commander.

FUNCTION: Coordinate and direct the treatment of patients within the Casualty Collection Area (CCA)

DUTIES:

- Don appropriate identification vest titled “**TREATMENT OFFICER**”.
- Obtain situation briefing from EMS Command.
- Verify medical communications network:
 - Freq. to Command:**
 - Freq. to EMS Operations Officer:**
 - Freq. to Triage Officer:**
 - Freq. to Transport Officer:**
- Establish and identify Casualty Collection Area (CCA) and communicate their location to the EMS Commander.
 - Immediate**, marked with RED:
 - Moderate**, marked with YELLOW:
 - Delayed**, marked with GREEN:
 - Areas must be large enough to accommodate patients and medically trained personnel that are providing treatment.
- Assign medically trained personnel to the CCA(s) and contact medical command as required.
- Ensure that an adequate amount of medical equipment is available to provide treatment at the CCA(s). Communicate equipment needs to the EMS Commander and/or the EMS Operations Officer.
- Ensure that an adequate number of medically trained personnel, both BLS and ALS, are available to provide treatment at the CCA(s). Communicate manpower needs to the EMS Commander and/or the EMS Operations Officer.
- Ensure that patients arriving at the CCA(s) have been triaged and prioritized.
- Ensure that all patients receive treatment that is appropriate for their condition.
- Determine the transport priorities of patients and coordinate their movement from the CCA(s) with the Transport Officer.
- Establish an area adjacent to the CCA(s) for Non-Injured individuals.
- Coordinate operations within the Treatment Sector with other sector officers.
- Provide EMS Command and/or the EMS Operations Officer with updates as to the operations within the Treatment Sector, including notification when all patients have been moved from the PCS(s).
- Maintain documentation as to operations within the Treatment Sector.
- Terminate, with consensus from the EMS Commander and/or the EMS Operations Officer, operations at the PCS(s) and re-assign personnel as directed.

TREATMENT TEAM MEMBER CHECK SHEET

PERSONNEL ASSIGNED: First Responder, EMT, Paramedic, Physicians, Nurses or other qualified persons as designated by the Treatment Officer.

FUNCTION: Responsible for treatment of patients in priority treatment areas, as assigned to by the Treatment Officer.

DUTIES:

- Provide treatment to patients that is consistent with the scope of practice of the provider.
- Obtain patient vital signs and **LEGIBLY** record them on the triage tag
 - Time vital signs taken.
 - Lung sounds.
 - Pulse.
 - Respiration.
 - Blood pressure.
 - Level of consciousness by use of the A.V.P.U.scale.
- LEGIBLY** record other patient information on triage tag;
 - Patient name, if known.
 - Age, approximate if not known.
 - Sex.
 - Treatment provided.
 - Indicate area of patients' injury(s) on anatomical diagram.
 - Indicate patients' primary injury(s).
 - Any other information deemed important, e.g., significant past medical history.
- Report changes in patients' status that might require a change in their transport priority, to the Treatment Officer.
- Prepare patients for transport to medical and specialized treatment facilities.

PRIORITIES OF PATIENTS AT CASUALTY COLLECTION AREA

A. UNINJURED - WHITE TAG

An area adjacent to the disaster site should be established for those “patients” that have been involved in a disaster but have sustained no injuries. Non-injured individuals that subsequently complain of injuries may be re-triaged and moved to the appropriate patient collection station.

B. PRIORITY 1 PATIENT - RED TAG

Serious injuries that have life-threatening implications or will become life threatening due to shock and/or hypoxia; are capable of being stabilized; require constant care and are given a high probability of survival if given immediate care and prompt transportation to an appropriate medical facility. Injured emergency responders and patients with uncontrolled emotional disorders are also placed in this priority.

C. PRIORITY 2 PATIENT - YELLOW TAG

Serious injuries which are not yet life threatening; no severe shock or hypoxia; high probability of survival and can withstand delayed transport until most red tagged patients have been stabilized and/or transported. These patients should also be transported to an appropriate medical facility.

D. PRIORITY 3 PATIENT - GREEN TAG

Minor injuries without systemic implications and can withstand delayed transport until most priority 1 and 2 patients have been stabilized and/or transported.

NOTE: Consideration should be given to having these patients transported to one or more hospital(s) which is/are more distant from the disaster scene than other hospitals(s) and which will probably not be receiving several Priority 1 or 2 patients. This will prevent the unnecessary taxing of any one hospital’s resources.

E. DECEASED PATIENT - BLACK TAG

Deceased patient(s) should not be moved unless necessary to access or treat surviving victims. If it becomes necessary to move a deceased victim then the location and position that the deceased was found in must be noted in order to assist in identification and/or further investigation.

TRANSPORTATION SECTOR OFFICER (designated by the EMS Commander)

The Transportation Sector Officer is directly responsible to the EMS Commander for coordinating the transportation of victims to appropriate medical facilities in an expeditious manner. These duties shall include:

1. Establishing and identifying ambulance staging / transportation areas that are easily accessible from the Casualty Collection Areas. Access and egress must be taken into account and the location shall be communicated to the EMS Commander. This may also require, at times, establishing a helicopter-landing zone in coordination with the Fire Commander.
2. Determining the treatment capabilities, “beds available”, of receiving hospitals within the area of the disaster through the communications center.
3. Determining the transportation needs for the potential number of patients that will be treated at the Casualty Collection Areas. Coordination with the Triage and Treatment Sector officers to obtain exact numbers is suggested.
 - In determining the transportation needs, keep in mind non-EMS forms of transportation, e.g. school buses to transport large numbers of minor injuries.
4. Accepting patients from the Casualty Collection Areas and assigning them to vehicles, ground transport OR aeromedical, for transportation to appropriate receiving facilities. The Transportation Sector Officer will designate which facility the patient(s) are to be transported too.
 - In Mass Casualty Incidents, effective utilization of available EMS transportation resources is critical. As such, multiple patients should be assigned to EMS vehicles that are transporting to facilities. For every priority 1 patient assigned to a transporting EMS unit, at least 1 priority 2 or 2 priority 3 patients should also be assigned to that unit for transport, (keeping in mind what sort of immobilization devices have been applied).
5. Communicating with receiving facilities with regards to an ambulance vehicle’s ETA to that facility, the number of patients on-board that unit, the priority of the patient(s), their triage tag number, and their primary injuries. Transporting units are not to give individual reports.
6. Maintaining a written record of: each patients priority, primary injury, disaster tag number, emergency vehicle assigned to transport the patient, hospital facility to which the patient was sent, and the time the patient left the scene.

TRANSPORTATION OFFICER CHECK SHEET

PERSONNEL ASSIGNED: EMT, Paramedic, or other person as designated by the EMS Commander.

FUNCTION: Coordinate the transportation of patients to medical and specialized treatment facilities.

DUTIES:

- Don appropriate identification vest appropriately labeled “**TRANSPORTATION OFFICER**”.
- Obtain situation briefing from EMS Commander.
- Assess situation;
 - Location of Casualty Collection Area (s).**
 - Ambulance vehicle access.**
 - Ambulance vehicle egress.**
- Establish ambulance staging area.
- Establish ambulance “loading” area.
- Verify medical communications network:
 - Freq. to Command:**
 - Freq. to EMS Operations Officer:**
 - Freq. to Triage Officer:**
 - Freq. to Treatment Officer:**
 - Freq. to Hospitals:
- Determine the treatment capabilities and “beds available” of receiving facilities within the area of the disaster using the communications center.
- Coordinate with the Triage and Treatment Sector Officers to determine the transportation needs for the potential number of patients that will be treated at the Casualty Collection Area(s).
- Coordinate with the Fire Commander for the establishment of a landing zone for aeromedical services.
- Consider alternate means of transportation for large numbers of class III patients, e.g. school buses, wheel chair vans, etc.
- Request ambulances from staging area as needed.
- Accept patients from the Casualty Collection Area(s) and assign them to ground transport **OR** aeromedical services for transportation to appropriate receiving facilities.
- Provide communications report to receiving facilities on each patient transported.
 - Patients priority.
 - Primary injury(s).
 - Triage tag number.

- Transporting unit.
- Time unit departed scene enroute to facility.
- Complete and maintain the bottom portion of each patients triage tag as a record of the patients' transportation.
- Ensure that an adequate number of transport capable vehicles is available. Communicate vehicle or manpower needs to the EMS Commander and/or the EMS Operations Officer.
- Maintain record of operations within the Transportation Sector through the use of the Transportation Officer Patient Status Sheet.
- Verify the final patient count with the Triage and Treatment Sector Officers in order to accurately determine whether all patients have been accounted for and transported from the scene.
- Provide the EMS Commander and/or the EMS Operations Officer with updates on operations within the Transportation Sector, including notification when all patients have been received from the Casualty Collection Area(s) and transported from the scene.
- Terminate, with consensus from the EMS Commander and/or the EMS Operations Officer, operations within the Transportation Sector.

ADDITIONAL OFFICERS ASSIGNED BY THE EMS-IC

These Positions are assigned based on availability. If sufficient personnel are not available, EMS-OIC must also handle these functions or assign these duties to another officer.

EMS COMMUNICATIONS OFFICER (Designated by the EMS Official)

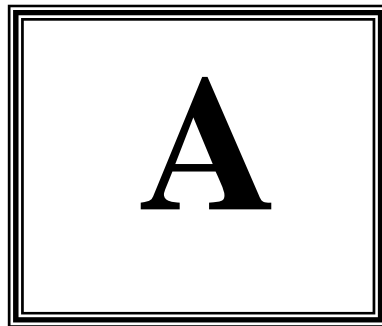
1. Establish and maintain EMS communications capabilities at the Command Post.
2. Determine from Communications Center, appropriate frequency or frequencies to be used for all EMS communications at the scene.
3. Establish a working arrangement with the Police, Fire, and Rescue Communications Officers.
4. Regulate and curtail EMS radio transmissions over the assigned frequency(s) that are not of an emergency nature.
5. Responsible to the EMS-OIC.
6. Establish and maintain communications with receiving hospitals.
7. Log all ETA's, departure times, and destinations of departing ambulances.
8. Notify the Transportation Officer of responding emergency units and their ETA's.

SAFETY OFFICER

The Safety Officer is responsible for oversight of the entire operation to assure the safety of both emergency responders and the public. Monitors and assesses hazardous situations and develops measures for assuring personnel safety. Normal correction of unsafe acts or situations will be through the chain-of-command, however, the Safety Officer may exercise emergency authority to stop or prevent unsafe acts when immediate action is required. Reports to the Incident Commander.

1. Report to the Incident Commander and obtain a briefing.
2. Develop an appropriate safety organization to properly meet the needs of the incident.
3. Observe the emergency operation for hazards. Follow normal chain-of-command to address general safety problems. May exercise emergency authority to stop or prevent unsafe acts if imminent danger exists.
4. Assists the Incident Commander and Operations Officer in determining extent of hot (hazard) zone, collapse zone, or other high danger zones. Provides assistance in monitoring personnel operating within these zones.
5. Provides guidance to Public Information and Liaison as to areas that will not be accessible to them.
6. Keeps Incident Commander informed and attends all briefings in Command Post.
7. Assures services such as rehab, shelter, Critical Incident Stress Debriefing Team, food, and other areas critical to the welfare of the emergency responders are addressed.
8. Maintains safety and accountability for safety personnel.

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Response

Levels

Response Levels
Equipment Response
Notification

PURPOSE:

The purpose of this appendix is to have the information in place on a number of units that respond to any given emergency. This will provide each agency, as well as field personnel, an easier and more effective way of requesting additional units. It will also inform communication assistants whom to notify in the event of an MCI.

Level 1 10-24 Patients
(or when local resources are taxed to their limit)

3-ALS 1-BLS Appropriate Rescue Box Assignment for incident
Notification to Squad Officers (Using Officer Tones)
All Local Hospitals and Trauma Centers
Air units on Stand By

Level 2 25-39 Patients

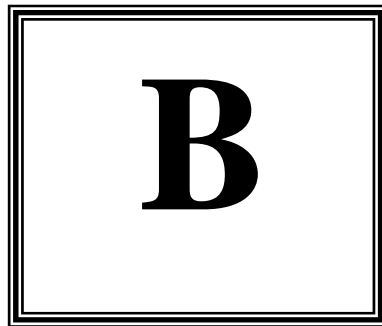
5-ALS 2-BLS Appropriate Rescue Box Assignment for incident
2 -QRS if logged on
Closest MCI Unit to the scene
Next due MCI Unit on standby
Notification to Squad Officers (Using Officer Tones)
All Local Hospitals and Trauma Centers
1 Air unit dispatch to scene, 1 on standby
EMS/EMA Office 24 Hours a Day
Command Bus (municipal or county) on Standby

Level 3 Greater than 40 patients

7-ALS 3-BLS Appropriate Rescue Box Assignment for incident
3-QRS if logged on
1 MCI Unit (To the Scene)
1 MCI Unit (Relocated to Closest Squad or Fire Department)
Notification to Squad Officers (Using Officer Tones)
All Local Hospitals and Trauma Centers
2 Air Units dispatch to the scene and third on Stand By
EMS/EMA Office 24 Hours a Day
Command Bus (municipal or county) automatically to the scene

***Dispatch Center should consider moving up units into effected area.**
*These numbers are a guidelines and should be adjusted as needed.

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Code Levels

Response Code Levels

PURPOSE:

The purpose of this appendix is to provide early notification to County EMS units as events change due to a major MCI, an incident(s) taxing the region beyond available resources or pending weather conditions.

Code Green: Daily Operations

Code Yellow: Weather warnings, Major MCI, any incident(s) taxing the region beyond available resources.

Squads:

- Start planning to bring crews in-house and putting additional ambulances into service

Dispatch Center:

- Start moving up units not affected by the condition into the affected area.
- Notify EMS/EMA Offices (or Directors after normal business hours, weekends or holidays).
- Alert all hospitals and trauma centers of status change and hospital diversions are cancelled until the incident is brought under control.

MCI Units:

- Make staffing arrangements for possible deployment

Code Red: Weather affecting the County, Major MCI or incident(s) taxing system, evacuation of hospital or nursing home, riots or major police action.

Squads:

- Bring crews in-house and put additional ambulances in-service.

Dispatch Center:

- Start moving up units not affected by the condition into the affected area.
- Notify EMS/EMA Offices (or Directors after normal business hours, weekends or holidays).
- Alert all County hospitals and trauma centers of status change and that all diversions are cancelled until the incident is brought under control.

MCI Units:

- Staff units and deploy per directions from Bucks County Radio Room

PROCESS:

Default Code level will be Green. As events or conditions change, the Communications Center will announce the change with information provided by the EMA/EMS Office or information from the field units. Downgrades would be conducted with the same information and cooperation.

- Code status changes will be announced along with the affected zones and municipalities.
- EMS Chief will be paged via alpha group page
- Printout sent to all Squads, fire companies, police departments, and hospitals

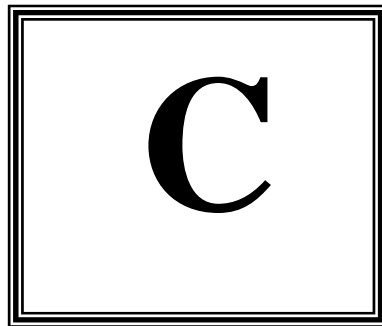
Bucks County Squads will be divided into three (3) regions for code status changes.

- Northern Squads: 108, 123, 124, 126, 141, 142, 151
- Central Squads: 125, 134, 135, 122, 129, 115
- Southern Squads: 100, 113, 114, 115, 139, 145, 154, 155, 167, 168, 185, 186

Code status changes can include one (1) all or any combination of the regions.

- Example: “Southern Bucks County is Operating under a condition Red in Bristol Township”

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**School Bus
Accidents**

ACCIDENTS INVOLVING SCHOOL BUSES

PURPOSE:

To establish a standard means of triaging, treating, and transporting children involved in an accident while riding the school bus. To avoid over taxing local emergency service resources and hospital personnel during minor accidents involving many children whose parents cannot be contacted. Also to establish criteria where children who are not injured can be released to school district authorities to reduce the emotional, logistical, and financial impact of the incident for all involved.

POLICY:

Upon the arrival of the first unit to the scene, incident command should be established and the member of the team with the highest level of training should initiate triage.

Patients who are minors and do not require treatment in the emergency room may then be left in the care of school district authorities with permission from a command physician. If at any time EMS personnel are unsure of a minor health status, the patient's well being is to be kept in the best interest and the patient should be transported to the emergency department.

PROCEDURE: The detailed procedure for this policy is as follows:

Upon receipt of a call reporting a motor vehicle accident involving a school bus, the dispatch center should dispatch two ambulances or a minimum of an ambulance and a first responder company.

Upon the arrival, the first unit to the scene, incident command should be established and the member with the highest level of training should initiate triage. A few facts must immediately be established. First, the mechanism of the accident; Second, are there any complaints of injuries; and finally, how many people are involved in the incident. Additional EMS units may be called for or their response or cancelled as the IC deems fit. Patients with obvious injuries are to be triaged and transported as in any other incident. Adults involved in the incident may refuse care or transportation according to local protocol.

Minors who were on the school bus and have no complaints or very minor complaints should be left on the bus if it is safe or directed to the holding area. These minors are then to be individually spoken to and assessed by EMS personnel. As the minors are assessed a log will be completed stating the following information:

- Minors Name
- Minors Age
- Level of Consciousness
- Complaints (none if there is no complaint)
- Position on Bus
- Triage and transportation Status

As these remaining patients are assessed, they will be divided into two categories: those that require evaluation in the Emergency Department and those who EMS personnel feel do not require Emergency Department evaluation.

Any minor patients that do require evaluation in the emergency department at this point shall be transported to one facility by means, at the discretion of the triage Officer or IC. EMS personnel are to keep in mind that continuity of care must be kept intact and if large numbers of patients with minor injuries are transported by alternate means such as a bus or van, an EMS responder must accompany those patients to the receiving facility.

Any minor patients that do not require further evaluation may be released to school district authorities after contacting a medical command and receiving permission to release the minors. **The EMS personnel on scene must contact medical command and receive permission to release the minors.** A school district authority is defined as principal, vice principal, or other administrative district personal with authority to take charge of the students. It is not advisable to release students to school nurses, teachers, parents, neighbors, etc. Allow the school district to release any minors to their parents. The name of the medical command physician must be documented as well as the name, position and signature of the school district

official receiving the children. The command physician reserves the right to require the children be transported to the emergency department. Should the command physician deny permission to release the minors on scene, the minors are to be transported to one facility for evaluation. This may be done by alternate means so long as the continuity of care is not broken.

All patients with no complaints or very minor injuries are to be transported to one facility. This will allow for better accountability of the patients and ease the problems of the school district and parents locating their children. The IC will be responsible to inform the receiving facility of the situation prior to transportation of the injured patients.

Patients with significant complaints or injuries will be transported as directed by the IC or designee, keeping in mind trauma protocol and not to overtax one facility with patients who may require definitive care.

ALTERNATE MEANS OF TRANSPORTATION

If there are a large number of patients that require transportation to a medical facility, and their injuries do not necessarily require transportation in an ambulance, an alternate means of transportation may be sought. Alternate means of transportation may include a bus, a mini-bus, or a passenger van. The school district involved will usually have a representative on scene and may be able to provide one of these alternate means of transportation.

When one of these means is used, continuity of care must be adhered to and at least one EMS responder must ride to the receiving facility with the patients.

Examples of patients who may be considered for transportation by alternate means include patients with no complaints that are to be evaluated and patients with minor soft tissue injuries.

SPECIAL SITUATIONS:

Although this policy allows for EMS personnel to make a determination whether a patient requires transportation to the emergency department or not, EMS personnel are reminded to always err on the side of caution. If there is a doubt, transport the patient.

EMS personnel are also cautioned to look at mechanism of injury when evaluating patients. Minors who were on a bus that suffered severe damage or that rolled over should be evaluated in the emergency department regardless of complaints or lack thereof.

Minors triaged to be released will be transported to the hospital at the request of the school district representative on scene if he/she deems fit.

OTHER APPLICATIONS OF THIS POLICY:

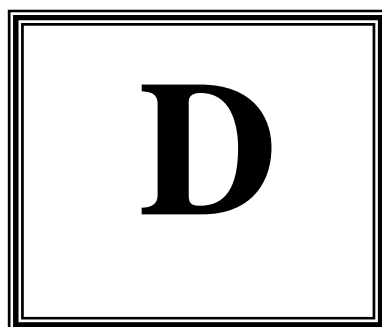
The concepts of this policy may be applied to any accident involving any school district vehicle.

Various school districts own and operate a wide variety of vehicles at various times throughout the day. If a school district vehicle is involved in a minor accident and there are no complaints or obvious injuries, any minors involved may be released to the school district representative on scene. Providing that a command physician has given permission for the patient(s) to be released.

WHERE THIS POLICY CANNOT BE APPLIED:

This policy is solely intended for minors who are riding in school district vehicles. This policy **cannot** be applied to minors involved in accidents in private vehicles whose parents cannot be contacted, or minors in private vehicles who are in the care of non-related adults, or minors who are riding on publicly or privately owned vehicles such as SEPTA busses and etc.

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Response to

Chemical/Biological/Nuclear Agents

Response to Chemical/Biological/Nuclear Incidents: Including Unknown Powders

Biological Agents (Examples – Refer to CDC Guidelines for current information)

<i>Bacteria</i>	<i>Viruses</i>	<i>Toxins</i>	<i>Chemical</i>
Anthrax	Smallpox	Ricin	Blister
Tularemia	Ebola	Botulinum	Nerve
Plague	VEE	SEB	

General Properties/Information

- Nonvolatile (will not evaporate)
 - May be effective when dispersed as an aerosol or airborne powder
 - Respiratory tract is the primary route of exposure
 - Other routes of exposure include open skin or unprotected membranes (eyes/nose) with certain agents
 - Weather conditions play a major role in effective dissemination outside of buildings
-
- Determine “TIME” between when people were first “exposed” and when the incident was reported. Was the report and reaction to substance immediate or delayed?
 - Assess if patients are symptomatic (Depending on agent symptoms do not show for hours or days post exposure. People complaining of immediate symptoms may be psychogenic, have unrelated ailments or may have been chemically exposed)
 - Assess the physical state of the suspected material. Biological agents do not pose an immediate respiratory threat if in liquid form. If the agent is in a powdered form and is not disturbed, it does not pose an immediate respiratory threat.
 - A biological agent can be a hazardous material and should be treated as such. Manage the scene as a hazardous material incident and utilize a unified command structure.

Self-Protection

- Use SCBA, or approved chemical/biological, gas particulate, air purifying respirator (APR) or other suitable full-face (PAPR) respiratory protection as authorized by the incident commander.
- Wear two pairs of issued medical gloves (vinyl or latex)-double gloving technique.
- Wear issued personal protective clothing or other suitable and authorized clothing ensemble.

On Scene Actions & Considerations

- Approach scene upwind
- Stage additional personnel and units upwind and at level 1 staging distance.
- Use issued personal protective clothing and SCBA (or authorized full-face chemical mask).
- Cordon area and restrict entry to authorized and protected personnel ONLY.
- Set up Hot, Warm and Cold zones.
- Call early for hazmat team(s) and other EMA response resources, and request bomb squad if needed.
- Incident commander to contact County communications to declare a WMD event for C.A.D. notes.
- County Communications to notify EMA, EMS, and FBI, etc of WMD declaration of scene commander.
- Remove potentially exposed persons from inside of structure to an outside cordoned area.
- Obtain name, address, and telephone number of these potentially exposed people.
- DO NOT disturb the package or material. Isolate it. Remember the letter, package, or other item(s) could be “booby-trapped”. If suspected, use bomb squad to render the device safe. Also, be alert for secondary devices on or around the scene.
- Treat the entire scene as a crime scene and attempt to preserve any possible/suspected evidence.
- Anticipate that the incident will draw many reporters, TV crews, and helicopters.
- Establish a media sector immediately and provide adequate staffing.
- Provide timely and medically accurate information to the news media early to reduce public fear.
- Request a designated phone number at the EOC to have an information line for public inquiries.
- Request the FAA to restrict air space to reduce the chance of collisions and eliminate effects of downdraft on the biological material.
- Use the hazmat team to put the letter, package, or other item(s) containing the suspected biological agent into a biohazard bag. Then put the bag into another biohazard bag and wet the outside with household bleach. Place the double-bagged material inside a suitable plastic or metal over-pack container. Wet the outside of the bag with household bleach. Seal the over-pack container.

Other Actions and Considerations

- ❑ Notify County's health department and area hospitals of situation.
- ❑ Consider activation of the County Emergency Operations Center (EOC) with advice from EMA.
- ❑ Establish unified command (i.e., EMS, fire, EMA, Hazmat, law enforcement, FBI, health).
- ❑ Operate forward command post.
- ❑ Utilize published resources and job aids from federal agencies.
- ❑ DO NOT allow possibly affected people to leave the scene without authorization from the County Health department, and the FBI.

Emergency Medical Actions

- ❑ Avoid all contact with suspect powder, anthrax can affect the body via respiratory, gastrointestinal and dermal routes. Avoid any action that would place the powder in the air to be inhaled.
- ❑ Consider placing respiratory protection on those within the immediate area as the suspect powder.
- ❑ Follow decontamination procedures below and provide supportive care for symptomatic conditions.
- ❑ Transport after decontamination, to a facility that has been notified of your arrival and ETA.
- ❑ Hospital staff should follow established guidelines for treatment of possible exposure to anthrax.
- ❑ Consult with public health authorities to determine whether antibiotic prophylaxis is needed for exposed persons, including first responders.
- ❑ Obtain the name and contact information of ALL potentially exposed persons in case later lab tests determine a specific pathogen is present.

Decontamination

- ❑ Set up Emergency Decontamination Corridor System (EDCS) or other suitable system.
 - ❑ Decontaminate people who handled the package or material by having them go through the EDCS. Use household liquid or bar soap if available. This is preferable over use of bleach. If bleach is used use diluted household bleach (1 part bleach to 9 parts water). Apply the diluted bleach to exposed skin where the suspected agent powder or liquid contacted it. Rinse the diluted bleach solution with water after 5-15 minutes of application.
 - ❑ Decontaminate the people in the immediate area of the suspect material by having them go through the EDCS and just have them remove their clothing.
 - ❑ Have other people in the building who were not in contact with the package or material or were not in the immediate area, just go outside into fresh air in a controlled cordoned area. Consider use of "air decontamination", i.e. use PPV or other fans to blow air across their clothing.
-

Common Decontamination Terminology:

Thorough Decontamination

- The patient has been completely or sufficiently decontaminated at the scene of an incident. No further decontamination is required and the patient and crew are safe to enter the hospital.

Gross Decontamination

- The patient has been grossly decontaminated/rinsed off at the scene. These patients are generally safe for transport to the hospital however may require additional decontamination at the hospital to achieve thorough decontamination. This may require showering the patient, especially in areas such as underarms, private areas, and feet that may not have been able to be decontaminated at the scene.

Contaminated

- It is the general rule that patients are not to leave a scene and be transported by EMS contaminate, however, situations arise where the patient may not be decontaminated or it may not be known until the ambulance is enroute to the hospital that the patient is contaminated.

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Critical Incident

Stress Management

CRITICAL INCIDENT STRESS MANAGEMENT

Critical Incident Stress Management (CISM) is an essential component of the management of a major incident response. The services provided by trained personnel in CISM are critical to the health of all emergency service personnel involved in the incident.

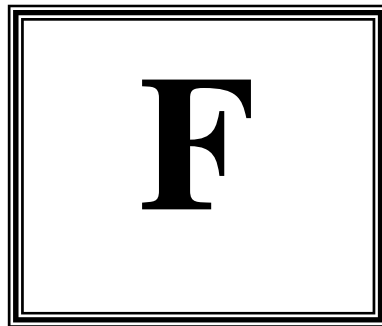
Upon the confirmation of a major incident Level 2 or Level 3, Bucks County Department of Communications will alert the Bucks County CISM team. Team members may choose to respond to the scene of the incident, and report to the unified command post. CISM team members will provide assistance to commanders in an advisory capacity and in support of emergency service personnel. The CISM team is available to respond to any incident, regardless of the number of casualties, when the officer in charge deems that CISM services may be helpful.

During the incident, CISM team members will be made available to emergency service personnel for private consultations. Team members will be able to identify emergency service personnel in possible need of rest, or temporary relief from duties. Defusing sessions will be made available to those emergency service personnel who feel the need for this service.

Immediately following the incident, the CISM team will provide demobilization services for each unit involved. These short sessions will include the distribution of information on CISM, tips for maintenance of emergency service personnel health, defining possible signs and symptoms of stress, and CISM contact information.

Twenty-four to seventy-two hours following the incident, at a separate location, the CISM team will hold a debriefing session for all emergency service personnel involved in the incident. The location of the debriefing will be selected to be adequate in size for the anticipated group and free from distractions and interruptions. This debriefing will be neutral non-accusational critique. The intent of the debriefing is to provide stress education, reassurance, and a mechanism for ventilation of feelings.

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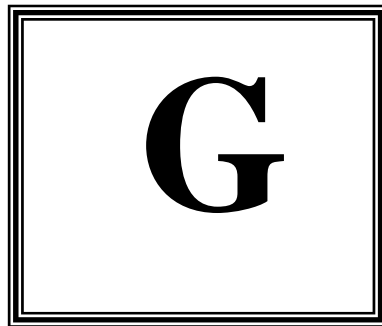


**Family
Management**

FAMILY MANAGEMENT

THIS SECTION TO BE DEVELOPED

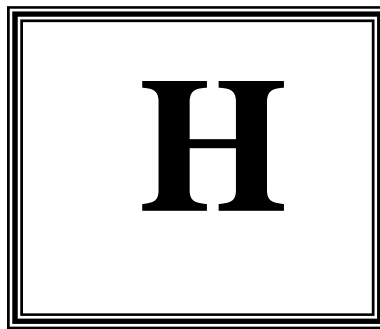
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**EMS Threat
Level Guidelines**

	Physical Security	Operations Management
SEVERE Severe Risk of Terrorist Attacks	<p>All actions from LOW (green), GUARDED (blue), ELEVATED (yellow) and HIGH (orange) plus:</p> <ul style="list-style-type: none"> • Reduce access points to absolute minimum necessary to sustain health care operations. • Consider relocation of personnel from targeted or nearby facilities, as necessary • Conduct daily briefing of security force to include identification of potential threats and vulnerabilities. • Review emergency action plan - drill as necessary to assure an effective response. • Alert all personnel in area of potential threat (via EOC) so additional casualties can be prevented or severity reduced. 	<ul style="list-style-type: none"> • Maintain 24-hour operations. • Activate agency disaster plans. • Mobilize pre designated personnel EMS personnel and vehicles. • Report any patients with symptoms of ricin, nerve agents or cyanide poisoning to medical command immediately. • Notify county EMA when EMS systems are being overwhelmed and assistance is needed. • Consider activating a regional EMS council operations center and/or function at a county EOC (regional councils). • Review protocol for responding to potentially dangerous environments, i.e., dangerous gas, radiologic contamination, unusual powder present. • Should a service inadvertently initiate transport of a contaminated patient, call medical command prior to off loading the patient. Do not contaminate the hospital inadvertently. • Consider CISM for staff. • If called to respond to suspicious event or explosion, consider the threat of secondary devices and proceed with great caution. • Consider that an explosion may also be a contaminated site with radiological (dirty bombs) or chemical agents.
HIGH High Risk of Terrorist Attacks	<p>All actions from LOW (green), GUARDED (blue) and ELEVATED (yellow) plus:</p> <ul style="list-style-type: none"> • Anticipate need for law enforcement to assist at scene and en route to scene. 	<ul style="list-style-type: none"> • Notify medical command physicians and medical command facility medical directors. • Review agency plan for special populations (children, elderly, homeless, etc.) • Refresh all staff on symptoms and interventions for WMD. • Reinforce the need for personal protection equipment for personnel. • Distribute materials explaining hazards and activities EMS personnel can take to protect themselves; and to clean vehicles and equipment. • Be suspicious of any calls for EMS to hotels, apartment buildings, restaurant shopping malls, etc., for more than one patient experiencing the same symptoms. Verify that 911 center has also alerted law enforcement. • Determine supply needs, including appropriate medications/antidotes, number of ambulances needed and being utilized. Assure appropriate supply line. • Review response to radiological contaminated scenes and patients and the decontamination required before patients are transported in an ambulance.
ELEVATED Significant Risk of Terrorist Attacks	<p>All actions from LOW (green) and GUARDED (blue) plus:</p> <ul style="list-style-type: none"> • Brief key personnel - threats, changes to security patterns, potential action plan. • Communicate with all staff the need to enhance security awareness. • Determine the need to restrict building access points - escort personnel entering controlled areas. 	<ul style="list-style-type: none"> • Review agency disaster plan. • Report any unusual activity that might indicate an interest in using ambulances for access to scenes and locations • Pre designate personnel to respond to biological calls. • Pre designate personnel to assist at inoculation centers. • Identify vehicles to transport patients with communicable diseases. • Review mass casualty incident kit: triage tags, vests for ICS, etc. • Consider alternate routes in case the infrastructure (highway, bridge, tunnel, etc.) is disrupted. • Conduct briefing by infection control personnel.
GUARDED General Risk of Terrorist Attacks	<p>All actions from LOW (green) plus:</p> <ul style="list-style-type: none"> • Report suspicious persons, items, vehicles, unidentified vehicles parked in an unusual manner. • Assure that emergency vehicles are secured at all times. • Increase liaison with local agencies, regional EMS councils to monitor threat. • Advise staff of their individual and departmental security responsibilities. 	<ul style="list-style-type: none"> • Brief leadership and staff of elevated threat posture - emphasize personal and family preparedness; include safe location and activation plan. • Report any trends and patient symptoms to the hospital infectious disease coordinator.
LOW Low Risk of Terrorist Attacks	<ul style="list-style-type: none"> • Normal operations consistent with organizational Security Management Plan. • On-going emergency planning and drills. • On-going staff and new hire orientation. • On-going information sharing at meetings • All staff issued security credentials (badges) and wears them while on duty. 	<ul style="list-style-type: none"> • Provide photo identify card to staff. • Review and update personnel recall and mobilizations rosters. • Arrangements for fuel, repairs and recovery services. • Assure CISM intervention is available. • Obtain training in agents/diseases; incident and unified command; triage, etc. • Report any trends and patient symptoms to the hospital infectious disease coordinator.

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Rehab

EMERGENCY INCIDENT REHABILITATION

The United States Fire Administration proposes that the purpose behind any rehabilitation plan is, "To ensure that the physical and mental condition of members operating at the scene of an emergency or a training exercise does not deteriorate to a point that affects the safety of each member or that jeopardizes the safety and integrity of the operation".

The Incident Commander is ultimately responsible for ensuring the adequate provision of rehabilitation services at the scene of an incident. Under the Unified Command System, rehab services fall under the responsibilities of the Logistics Sector. However, as is often the case, EMS services can anticipate heavy involvement in the provision of rehab services to all emergency workers at the scene of a mass casualty incident.

The information that follows can be utilized as generally acceptable guidelines for Emergency Incident Rehabilitation at **ANY** emergency scene.

When Should Rehab Be Provided?

- ◆ All structure fires
- ◆ Large brush fires.
- ◆ Hazardous materials incidents.
- ◆ Extended rescue operations.
- ◆ Temperatures greater than 80 degrees or less than 32 degrees.
- ◆ Multi department operations that last for greater than 2 hours, including Multiple / Mass Casualty Incidents.
- ◆ Training operations lasting greater than 2 hours.
- ◆ **At the discretion of the Incident Commander.**

Where Should The Rehab Sector Be Located?

- ◆ Up wind from the incident site in an area that is free from exhaust fumes from emergency or other vehicles.
- ◆ Depending upon environmental conditions, either in a cool, shaded area **OR** a warm dry area. This might entail the use of a nearby building, if available
- ◆ In an area with minimal noise disturbance from emergency operations, equipment or crowds
- ◆ Near the air cylinder refill station or the manpower staging area, if possible. Such a location would ensure that all emergency workers are seen by the Rehab Officer.
- ◆ Out of site of the incident, if possible. Emergency workers will have a difficult time being rehabilitated if they are watching the incident go on. They want to get back into the "game" too quickly
- ◆ In an area that has access for incoming units, should the transport of an individual in the Rehab Sector become necessary.
- ◆ In an area that will provide shelter from inclement weather.

When Should Emergency Workers Report To Rehab?

The United States Fire Administration recommends that the "two air bottle rule" or 45 minutes of work time be considered an acceptable level prior to mandatory rehabilitation. Members shall rehydrate while SCBA cylinders are changed. Firefighters having worked for

two full 30 minute rated cylinders, or 45 minutes shall be immediately placed in the Rehabilitation Area for rest and evaluation. Rest shall not be for less than 10 minutes and may exceed an hour as determined by the Rehab Officer, based on the member's physical appearance, condition and vital signs. Fresh crews, or crews released from the Rehab Sector shall be available in the Staging Area to ensure that fatigued members are not required to return to duty before they are rested, evaluated and released by the Rehab Officer. While these recommendations appear to be specific to fire department operations, it should be easy to adapt them for use in managing **ALL** of the emergency personnel at a Mass Casualty Incident.

How Should The Rehab Sector Be Staffed?

- ◆ A Rehab Officer shall be established for the management of the Rehab Sector and the personnel operating within it. This individual must have an operational portable radio that is capable of direct communications with the Unified Command Post.
- ◆ At a minimum, EMS should have BLS services and providers, (EMT's), available at the Rehab Sector. Depending upon the scope and severity of the incident and the availability of EMS resources, ALS services and providers may also be required.
- ◆ One officer from the fire service should be present to manage fire / rescue personnel and to reassign them after their rehab is complete.
- ◆ In the event of a large loss of life or extended rescue operations, (e.g. building collapse, plane crash), a member of the CISD team should be present to offer CISM services if needed.

What Type Of Equipment / Supplies Are Needed At The Rehab Sector?

- ◆ **ESSENTIAL EQUIPMENT AND SUPPLIES**
 - BLS Trauma Kit
 - Clipboards
 - Rehab Sector report sheets
 - Pens / Pencils
 - Fluids
 - Water
 - Juices
 - Activity Drinks
 - Oral Electrolyte Solutions
 - Water cooler(s), 5 gallon type
 - Misting Fan
 - Cups
 - Plastic Bags
 - Medical Equipment
 - Blood pressure cuffs and stethoscopes
 - Oxygen administration devices
 - Extra oxygen cylinders and regulators
 - Thermometers, electronic, disposable or tympanic.
 - Cold packs
 - Hot packs
 - Triage tags
 - Stair chair and/or stretcher
 - ALS medical kit and equipment, to include IV fluids and cardiac monitor, when such services are required and/or available
- ◆ **OTHER EQUIPMENT AND SUPPLIES**
 - Portable radio for communications with other sectors

- ❑ Awnings, tarp's
- ❑ Inflatable tent shelters

- ❑ Heaters
- ❑ Extra dry clothing, (jump-suits, sweat-suits, sweat-socks)
- ❑ Blankets
- ❑ Towels
- ❑ Traffic cones and emergency scene tape for establishing and identifying the Rehab Sector
- ❑ Hair dryers, (to dry wet heads and re-warm areas)
- ❑ Lighting
- ❑ Chairs, (plastic lawn type)
- ❑ Antibacterial soap, (liquid type)
- ❑ Food and energy type snacks

OPERATIONAL GUIDELINES

◆ HYDRATION

- ❑ A critical factor in the prevention of heat injury is the maintenance of water and electrolytes. Water must be replaced during training exercises and emergency incidents.
- ❑ During heat and physical stress situations, personnel should consume at least one quart of water per hour.
 - ❑ If an activity type beverage is used, it should be a 50 / 50 mixture of water and beverage solution and should be administered at about 40F.
- ❑ Rehydration is important even during cold weather operations. Despite outside temperatures, heat stress may still occur during firefighting or other strenuous activity where protective equipment is worn.
- ❑ **Alcohol and caffeine beverages should be avoided before and during heat stress!** Both of these interfere with the body's water conservation mechanism. Carbonated beverages should also be avoided.

◆ NOURISHMENT

- ❑ Food should be provided at the scene of extended incidents where units are engaged for three or more hours.
- ❑ Soups, broth's and stews are recommended as they are digested much faster than sandwiches and other types of fast foods. Fatty and salty foods should be avoided.
- ❑ Granola bars, apples, oranges and bananas also provide supplemental forms of energy replacement.

◆ REST PERIODS

- ❑ The "two air bottle rule" or 45 minutes of strenuous work time is the recommended level prior to mandatory rehabilitation.
- ❑ Rest periods should not be for less than ten minutes.
- ❑ Two hours of continuous duty should be followed by a fifteen to thirty minute rest/recovery period.
- ❑ In addition to liquids given in the Rehab Sector, personnel using SCBA should rehydrate with at least 8 ounces of fluid whenever their air cylinders are being changed.
- ❑ Fresh crews or crews released from the Rehab Sector must be available to ensure that fatigued personnel do not return to duty before they have been properly rehabilitated.
- ❑ Crews should be rotated from heavy or intense operations to medium duty operations then to light duty operations and vice versa.

- ❑ Personnel should not be moved from a hot environment directly into an air-conditioned area because the body's cooling system could shut down in response to the external cooling. An air-conditioned environment is acceptable after a "cool down" period in ambient temperature with sufficient air movement.
- ❑ Twelve hours are the maximum amount of time that **ANY** emergency personnel, **INCLUDING COMMAND**, should be continuously at an emergency scene, no matter how many rest /rotation sequences are provided.

◆ **MEDICAL EVALUATION**

- ❑ Personnel reporting to the Rehab Sector will receive evaluation and treatment for environmental emergencies as well as treatment for minor injuries.
- ❑ Heart rate should be checked as soon as possible during the rest period. If the heart rate exceeds 110 beats per minute then an oral temperature should be taken. If the temperature exceeds 100.6 F, he/she should not be permitted to return to duty and/or wear protective clothing.
- ❑ If the heart rate exceeds 110 beats per minute but the temperature is below 100.6 F, rehabilitation time should be increased.
- ❑ If the heart rate is less than 110 beats per minute, the chance of heat stress is negligible.
- ❑ Blood pressure may be checked as part of the medical evaluation in the Rehab Sector. However, in heat stress conditions blood pressure tends to drop as a person loses body fluids and the heart attempts to compensate by accelerating. The individual's pulse rate will be elevated while their blood pressure will be lower than his/her normal or anticipated level.
- ❑ If after continued rehabilitation, (additional monitoring of vital signs, rest and provision of additional fluids), no changes are observed in the personnel's physical condition, further advanced treatment, (EKG monitoring, establishment of IV's), and transportation to a hospital should be considered. If resistance to this is met by the individual, Rehab Sector personnel should seek the advice of a medical command physician and assistance from the fire service officer at the Rehab Sector in securing further treatment and transport.

◆ **DOCUMENTATION AND ACCOUNTABILITY**

- ❑ Personnel assigned to the Rehab Sector shall enter and exit the Rehabilitation Area as a crew. The following information shall be noted on the Rehab Check In / Out Sheet, a copy of which is provided in the appendices.
 - Unit or team number
 - Number of persons.
 - Time in.
 - Time out.
- ❑ Crews shall not leave the Rehab Sector until authorized to do so by the Rehab Officer.
- ❑ All medical evaluations shall be documented on the Emergency Incident Rehabilitation Report, a copy of which is provided in the appendices. Additionally, any individual that receives treatment beyond the standard medical evaluation mentioned previously shall have a Pennsylvania state patient report form completed for him/her.

Heat Index

RELATIVE HUMIDITY

		10%	20%	30%	40%	50%	60%	70%	80%	90%
TEMPERATURE	104	98	104	110	120	132				
	102	97	101	108	117	125				
	100	95	99	105	110	120	132			
	98	93	97	101	106	110	125			
	96	91	95	98	104	108	120	128		
	94	89	93	95	100	105	111	122		
	92	87	90	92	96	100	106	115	122	
	90	85	88	90	92	96	100	106	114	122
	88	82	86	87	89	93	95	100	106	115
	86	80	84	85	87	90	92	96	100	109
	84	78	81	83	85	86	89	91	95	99
	82	77	79	80	81	84	86	89	91	95
	80	75	77	78	79	81	83	85	86	89
	78	72	75	77	78	79	80	81	83	85
	76	70	72	75	76	77	77	77	78	79
	74	68	70	73	74	75	75	75	76	77

Note: Add 10 deg. F when protective clothing is worn and add 10 deg. F when in direct sunlight.

Humiture Deg. F	Danger Category	Injury Threat
Below 60 deg.	None	Little or no danger under normal circumstances
80 - 90 deg.	Caution	Fatigue possible if exposure is prolonged and there is physical activity.
90 - 105 deg.	Extreme Caution	Heat cramps & heat exhaustion possible if exposure is prolonged and there is physical activity.
105 - 130 deg.	DANGER	Heat cramps or exhaustion likely, heat stroke possible if exposure is prolonged and there is physical activity.
Above 130 deg.	EXTREME DANGER	HEAT STROKE IMMINENT!!

EMERGENCY INCIDENT REHABILITATION REPORT **INCIDENT:**

DATE:

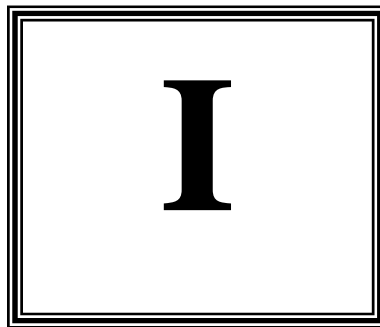
<u>Name / Unit #</u>	<u>Time(s)</u>	<u>Time / # Bottle(s)</u>	<u>BP</u>	<u>Pulse</u>	<u>Resp.</u>	<u>Skin</u>	<u>Temp.</u>	<u>Taken By</u>	<u>Complaints / Condition</u>	<u>Transport?</u>

REHAB OFFICER- CHECKLIST

COMPLETED

	Put on Gray Rehab vest or identifier																																																				
	Notify Incident Command and County that REHAB is in Service																																																				
	Select a REHAB AREA near the main Action Area (Near the SCBA Changing Area --- If a Fire Incident)																																																				
	Notify Incident Command or EMS Command of Your Location																																																				
	Obtain Equipment & Supplies to Operate the REHAB SECTOR:																																																				
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;"></td> <td style="width: 40%;"></td> </tr> <tr> <td>Portable Radio-- with good working Battery to link to Command</td> <td></td> </tr> <tr> <td>Salvage Covers-- for Ground Cover (Pull off of a near-by Engine w/ permission)</td> <td></td> </tr> <tr> <td>Traffic Cones-- for cattle chutes and boundary markers (approx. 12)</td> <td></td> </tr> <tr> <td>Stretcher and Stair Chair</td> <td></td> </tr> <tr> <td>Oxygen Supplies, Tanks and Regulators</td> <td></td> </tr> <tr> <td>"Cooling" and "Dry" Towels--- Cooler and Crate</td> <td></td> </tr> <tr> <td>Ice (Get from Freezer), Water and Cups</td> <td></td> </tr> <tr> <td>Activity Drink Mix (Use 50-50 Mixture)</td> <td></td> </tr> <tr> <td>Granola Bars</td> <td></td> </tr> <tr> <td>Timpanic Thermometers and Probe covers</td> <td></td> </tr> <tr> <td>Chairs or Benches for Seating</td> <td></td> </tr> <tr> <td>BLS Trauma Kit</td> <td></td> </tr> <tr> <td>Cooling Sprayers</td> <td></td> </tr> <tr> <td>Adequate Lighting</td> <td></td> </tr> <tr> <td>Clipboards and Log Sheets</td> <td></td> </tr> <tr> <td>Triage Tags and Pens</td> <td></td> </tr> <tr> <td></td> <td style="text-align: center;">COLD WEATHER</td> </tr> <tr> <td></td> <td>Hot Packs</td> </tr> <tr> <td></td> <td>Heavy Blankets</td> </tr> <tr> <td></td> <td>Grounded Electric</td> </tr> <tr> <td></td> <td>Supp. Heaters</td> </tr> <tr> <td></td> <td>Quartz Lights (Heat)</td> </tr> <tr> <td></td> <td>Windbreak/ Shelter</td> </tr> <tr> <td></td> <td>Hair Dryers</td> </tr> <tr> <td></td> <td>Spare Clothing</td> </tr> </table>			Portable Radio-- with good working Battery to link to Command		Salvage Covers-- for Ground Cover (Pull off of a near-by Engine w/ permission)		Traffic Cones-- for cattle chutes and boundary markers (approx. 12)		Stretcher and Stair Chair		Oxygen Supplies, Tanks and Regulators		"Cooling" and "Dry" Towels--- Cooler and Crate		Ice (Get from Freezer), Water and Cups		Activity Drink Mix (Use 50-50 Mixture)		Granola Bars		Timpanic Thermometers and Probe covers		Chairs or Benches for Seating		BLS Trauma Kit		Cooling Sprayers		Adequate Lighting		Clipboards and Log Sheets		Triage Tags and Pens			COLD WEATHER		Hot Packs		Heavy Blankets		Grounded Electric		Supp. Heaters		Quartz Lights (Heat)		Windbreak/ Shelter		Hair Dryers		Spare Clothing
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	Have EMS Command request that the Comm Center Announce the REHAB SECTOR's Location																																																				
	Work with the Sector Commanders and the Safety Officer To Direct Personnel to the REHAB AREA																																																				
	LOG IN, assess, LOG OUT all personnel seen in REHAB AREA																																																				
	Request FOOD SUPPORT Service- If Extended Operation																																																				
	Notify TRIAGE OFFICER if Intensive Treatment of any Personnel is necessary (Do TRIAGE if Necessary)																																																				
	Notify the appropriate agency's COMMAND OFFICER if any Of their personnel are sent to Hospital Facilities																																																				

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Triage Tags

TRIAGE TAG COMPLETION INSTRUCTIONS

The word **Triage** is French and roughly translated means “to sort”. This is exactly what we are doing when we triage,...sorting or placing into categories injured victims of a disaster.

The initial triage is a walk through by the Triage Sector Officer and is performed so that an approximate patient count can be determined. “Tagging” of patients according to the apparent severity of their injuries may also begin at this point if an adequate amount of personnel are available to do so. During initial triage, only that care that would correct immediate life-threatening problems, e.g. severe bleeding, airway problems, should be performed.

On extremely large incidents, such as those involving large or multiple buildings, it may be necessary to have several separate triage areas, e.g., 1st floor triage, 4th floor triage, east side triage, etc. The Triage Sector Officer should assign multiple triage/tagging teams for such incidents. As a general rule of thumb, one team for floor or one team per area of an incident should be utilized for these large incidents.

All patients should be triaged and tagged according to the patient priority categories referenced in these guidelines.

Filling Out the Triage Tag

Standard Triage Tag

1. First, determine the proper priority of the patient based upon your rapid assessment of the patient’s condition(s).
2. Remove the remaining colored sections by **CAREFULLY** tearing the tag at the proper perforation. **NOTE:** Each tag has four colored tabs; red, yellow, green and black, and bear the same five to six digit identification number. The first three tabs are perforated for easy removal. In the event that a patient needs to be re-prioritized after re-assessment, the remaining tabs can be removed to downgrade that patient’s priority. **PLEASE NOTE** that if a patient was originally triaged as delayed and their priority is upgraded upon re-assessment, it will be necessary to “re-tag” that particular patient. Also, if the victim has been involved in the incident but is uninjured, write UNINJURED across side one of the tag. In this way, those uninjured victims can be accounted for in one area and monitored for any late developing injuries or illnesses.
3. Complete each section as follows:
 - A. **Side One, (this is the side of the tag with the anatomical drawing):**
 - 1). Patients name: if possible and if time permits.
 - 2). Time refers to the time of initial triage.
 - 3). Age: if unknown, mark down an estimated age.
 - 4). Sex: Circle “M” or “F” in the section provided.
 - 5). Initial pulse, if possible and if time permits.
 - 6). Initial respiratory rate, if possible and if time permits.
 - 7). Initial blood pressure, if possible and if time permits.
 - 8). Level of consciousness through use of the AVPU scale
A - Alert
V - Verbal
P - Painful
U - Unresponsive
 - 9). Notes/Treatment: Just put down the key points, i.e., splinted, backboard, bandaged, etc. Keep in mind that further treatment received in the Patient Collection Stations must also be noted on the tag. If ALS care is given, list the procedures and times. E.g., IV NSS 1000cc, 1400 Hrs.

- 10). Anatomical Drawing: If appropriate, circle the area that corresponds to the injury site.
- 11). Transportation Officer: Leave blank, this portion of the tag is for the Transportation Officer to complete.

B. Side Two, (this is the side of the tag for noting injuries).

- 1). Check the box that corresponds to only the primary injury/illness found under the priority that the patient falls into, (1, 2 or 3). **NOTE:** Injured co-workers and patients with uncontrolled emotional disorders are prioritized as immediate.

C. Transportation Officer Portion.

- 1). This perforated portion is to be removed by the Transportation Sector Officer, or his designee, at the time that the patient is assigned to an EMS unit for transportation to a hospital.
- 2). Primary Injury/Illness: Write down the **primary** injury/illness under the block for the category/priority that the pt falls into, (1,2,3 or 4 for deceased).
- 3). EMS Unit: Write down the EMS unit name and I.D. number that will be transporting the patient.
- 4). Depart Time: Write down the time that the EMS unit left the incident site with the patient enroute to the hospital designated by the Transportation Sector Officer.
- 5). Hospital: Write down the name of the hospital that the patient is being transported to.

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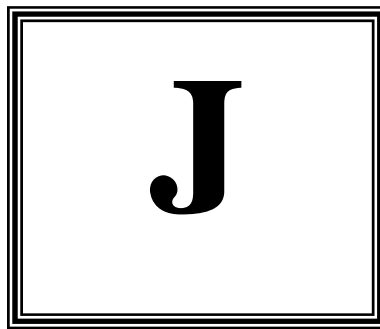
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Resources

MCI Units, EMS Unit Relocation, Surge Units, Hospitals

Bucks County Mass Casualty Units

The Bucks County EMS region has established Mass Casualty units. EMS services within the region have agreed to store, maintain and transport equipment to the scene of a Mass Casualty Incident. All vehicles maintain the same inventory for consistency of familiarization.

These units may be dispatched for:

- Mass casualty incidents
- Hazardous Material Incidents
- Hospital decontamination
- Rehabilitation assignments
- Special events that would deem appropriate to have an MCI unit on site
- Out of region mutual aid (surge capacity)
- Technical Rescue incidents

Current locations are:

- **MCI #1 - Tri-Hampton Rescue Squad – Station 115**
- **MCI #2 - Central Bucks Ambulance - Station 125**
- **MCI #3 - St. Lukes Quakertown – Station 108**
- **MCI #4 – Bucks County Rescue Squad – Station 143**

Dispatch Procedure:

- 1st due MCI Unit is dispatched directly into the scene
- If rehabilitation is required at the scene, the 2nd due MCI unit will be detailed
- 3rd or 4th due will be positioned as necessary to appropriately cover any additional incident needs or to adequately cover the region for any additional assignments.
- Hospital Decontamination assignments:
 - Closest available unit will be dispatched to assist hospital and fire department
- Code Yellow – Make arrangement to staff and deploy MCI Units
- Code Red – Staff MCI units and deploy per direction of Bucks County Radio Room.

Relocation of EMS Units

There may be instances or situations that deplete EMS resources in a specific area or the entire county. Besides the obvious large-scale incident, EMS resources could be unavailable due to an abnormally high call volume or units committed to incidents for an extended period of time.

For units committed to extended incidents, the dispatcher may ask the EMS commander if they wish a 2nd or 3rd due mutual aid squad with additional units logged on to relocate into their primary response area.

During times of a major incident or Code Yellow/Code Red, the Bucks County Communications will automatically start relocating units into the affected area(s). Squads with additional units logged on will automatically be the first to be relocated. Depending on the number of additional units or distance of these units into the affected area, dispatchers may also elect to relocate mutual aid units until additional units arrive in the area.

In order to equally cover the county, EMS units may be relocated to fire stations, hospitals, or other non-traditional geographical areas, such as intersections or shopping centers.

Logged on QRS units should also be included and considered into EMS resources relocation.

Surge Units

The Emergency Medical Services Office (EMS Office) of the PA Department of Health has established an ambulance response program to pandemic or catastrophic casualty events that exceed local, county, and regional resources.

Ten ambulance services have committed via contract with the EMS Office to deploy one staffed ambulance with two crews for a minimum of five days (two days travel; three duty days). While the minimum commitment is for five days, ambulance services may be deployed for less time or requested for up to two weeks. Each contracted service has agreed to supply, train, and provide PPE for six practitioners according to the contract's work statement.

The Bucks County Emergency Health Services will be responsible for activation of these units. BCEHS will also determine gathering points and task force leaders at the time of the incident.

EMS Organizations not part of the Surge Task Force are not permitted to respond to any incident without prior authorization of the EMS or EMA Office.

Hospital Resource Page

This page is dedicated to integrating county hospitals into the incident command system and EMA activities during:

- Code Yellow
- Code Red
- Hazardous Materials Incidents
- Decontamination activities
- EOC activations

Hospitals will have continuous internet connection in the emergency department and in the hospital's emergency operations center. Each hospital will monitor the FRED and or E-Team system at all times. During an alert activation, hospitals must supply the necessary information requested in the alert information.

All hospitals will be notified by the Bucks County Radio Room via the hospital intercom system of any hazardous materials incident or code level change.

The hospital ED staff will notify their appropriate supervisor and if necessary activate the internal emergency preparedness plan, incident command system, and emergency operations center.

Multiple Bucks County fire departments have been trained to assist hospitals with the decontamination process. Any hospital that is faced with multiple contaminated patients and unable to handle the increased capacity is to contact the Bucks County Radio Room and request the fire department to assist with decontamination.

Common Decontamination Terminology:

Thorough Decontamination

- The patient has been completely or sufficiently decontaminated at the scene of an incident. No further decontamination is required and the patient and crew are safe to enter the hospital.

Gross Decontamination

- The patient has been grossly decontaminated/rinsed off at the scene. These patients are generally safe for transport to the hospital however may require additional decontamination at the hospital to achieve thorough decontamination. This may require showering the patient, especially in areas such as underarms, private areas, and feet that may not have been able to be decontaminated at the scene.

Contaminated

- It is the general rule that patients are not to leave a scene and be transported by EMS contaminate, however, situations arise where the patient may not be decontaminated or it may not be known until the ambulance is enroute to the hospital that the patient is contaminated.

EMS Incident Support Team

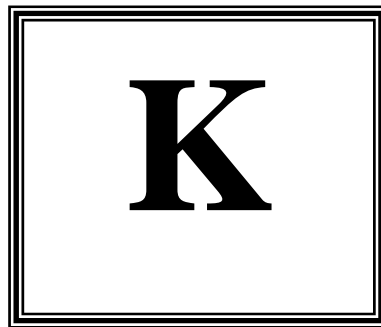
The purpose of this section is to acknowledge mutual aid of Bucks County Squad Chief officers whose organizations may or may not be involved in an incident. Due to the complexity of emergency incidents and the need for effective incident management, deputies may be needed at many levels of the incident command structure.

During an incident, an EMS chief officer may respond to assist. Upon arrival at a scene, the EMS chief officer will report to the EMS commander or staging area and offer assistance. The EMS Commander will determine where in the incident command structure the officer may be placed. An officer may be asked to take responsibility of a section or unit in order to free up personnel for other sections/units or to place transporting units back in to service. An officer may also be assigned to act as an assistant to command personnel or section/unit leaders.

It is understood that officers are not responding to take control of an incident. Many current and past Bucks County chief officers have many years of ICS experience. It is recommended to call on those experienced officers take advantage of their expertise and knowledge.

It is encouraged for all squad chiefs to communicate regularly with their surrounding counterparts in order to develop relationships and make mutual aid officer agreements.

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**Supplemental
Forms**

The forms in this Appendix are intended to be additional tools that may be used at a Mass Casualty Incident. The use of these forms is not mandatory, nor are they included elsewhere within this document.

Disaster and MCI Log Form

For use primarily by the EMS Commander and/or EMS Operations Officer. Through use of this form, documentation is established that provides for the following;

1. An hour-by-hour synopsis of the EMS operations conducted at a Mass Casualty Incident. Operations, problems encountered, and objectives attained can be easily noted within this format.
2. In the case of an extended operation, EMS Command may change hands. Use of this form provides any “new” commander with a history of operations conducted at the incident.
3. An excellent resource of the event for the writing of after action reports.

Incident Worksheet

For use primarily by the EMS Commander and/or EMS Operations Officer. In conjunction with the Disaster and MCI Log Form, the Incident Worksheet provides an overview of current objectives and current actions of the EMS component. The Incident Sketch portion of the worksheet provides an area for a general diagram of the scene. Areas of importance for EMS would be items such as vehicle access and egress routes, staging areas, patient collection and treatment areas, and the location of the unified command post.

Resources Summary Worksheet

For use primarily by the EMS Commander, EMS Operations Officer, or Transportation Sector Officer. Use of this sheet provides a quick reference to the EMS assets operating at the Mass Casualty Incident.

Hospital Resource Availability

For use primarily by the Transportation Officer. Use of this sheet, in conjunction with information provided by Eastern PA Medcom, provides a quick glance of the Hospital resources, (“bed count”), available within the Eastern PA EMS region. Also provides an area to document out-of-region hospitals that may have been queried for bed availability, (depending upon the size of the incident).

DISASTER AND MCI LOG FORM

Date:

Incident:

0100	
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0300	
0400	
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0600	
0700	
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0900	
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1100	
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DISASTER AND MCI LOG FORM

Date:

Incident:

1300	
1400	
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1900	
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INCIDENT WORKSHEET

CURRENT OBJECTIVES:

CURRENT ACTIONS:

INCIDENT NAME:

DATE:

TIME:

INCIDENT SKETCH	INCIDENT NAME:	DATE PREPARED:	TIME PREPARED:
PREPARED BY (NAME AND POSITION)			

HOSPITAL RESOURCE AVAILABILITY

INCIDENT NAME:

DATE:

HOSPITAL		PRIORITY 1	PRIORITY 2	PRIORITY 3
Frankford Bucks County Campus	A			
	U			
Lower Bucks Hospital	A			
	U			
Central Montgomery Medical Center	A			
	U			
Warminster Hospital	A			
	U			
Doylestown Hospital	A			
	U			
Grandview Hospital	A			
	U			
St. Luke's Quakertown	A			
	U			
Abington Memorial Hospital – Trauma Center	A			
	U			
Frankford Torresdale – Trauma Center	A			
	U			
Helene Fuld Medical Center – Trauma Center	A			
	U			
St. Mary Medical Center – Trauma Center	A			
	U			
Lehigh Valley Hospital – Trauma Center	A			
	U			
St. Luke's Bethlehem – Trauma Center	A			
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A = AVAILABLE U = USED

HOSPITAL RESOURCE AVAILABILITY

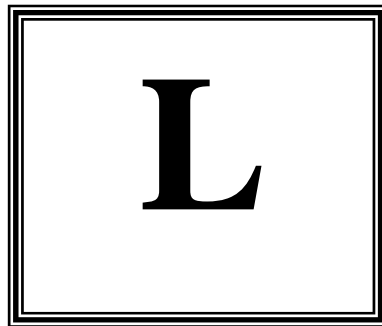
INCIDENT NAME:

DATE:

HOSPITAL	PRIORITY 1	PRIORITY 2	PRIORITY 3
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A = AVAILABLE U = USED

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Definitions

DEFINITIONS

Advanced Life Support (ALS) - The level of emergency medical care that utilizes basic life support measures, invasive medical procedures and drug therapy.

Ambulance - Any vehicle specifically designed, constructed or modified and equipped, and is used or intended to be used, and is maintained or operated for the purpose of providing emergency medical care to and transportation of patients.

Basic Life Support (BLS) - The level of emergency medical care that involves maintenance of the patient's airway, breathing and circulation. This level of care also includes basic bandaging and splinting of traumatic injuries.

Clear Text - The use of "plain English" in radio communications transmissions. Ten codes or agency specific codes are not used when using Clear Text.

Command - The act of directing, ordering and/or controlling resources by virtue of explicit legal, agency or delegated authority.

Disaster - An event, either natural or man-made, that is characterized by loss of human property, loss of human life, a potential for large number of injuries, separation of family members and an overall disturbance of routine operating procedures.

Dispatch Center - A facility from which resources are directly assigned to an incident.

EMS Commander - The individual that is responsible for the overall coordination of all EMS activities at a disaster scene.

EMS Operations Officer - The individual that is responsible for the coordination and management of EMS related resources at a multiple casualty incident. The Operations Officer acts as a liaison between the EMS Commander and other EMS providers on location.

Impact Area - The immediate area of an incident scene where the patients received their injuries and they were initially found.

Incident Commander - The individual responsible for the management of all operations at a disaster scene.

Mass Casualty Incident - An emergency incident involving the injury and/or death of a number of patients beyond what the jurisdiction is routinely capable of handling. Also called Multiple Casualty Incident or Multiple Patient Incident.

Morgue - An area on or near the incident site that is designated for the temporary placement of deceased victims.

Patient Collection Station (PCS) - A specific area, designated by the Treatment Officer, for the collection and treatment of patients prior to transport to a medical facility.

Post Incident Review - A reconstruction of an incident to assess the chain of events that took place, the methods used to control the incident and how the actions of emergency personnel contributed to the eventual outcome.

Priority Treatment Area - An area of the Patient Collection Station specifically designated for IMMEDIATE, SECONDARY or DELAYED patients.

Rehab Services - Services provided at a disaster for the rest, nourishment and hydration of ALL emergency workers.

Resources - All personnel and major items of equipment available, or potentially available, for assignment to incident tasks on which status is maintained.

Sector - A tactical level management unit having responsibility for either a geographic or functional assignment.

Staging Area - An area where personnel and equipment are initially assigned to respond to and to await further assignment.

Transportation Sector Officer - The individual that is responsible for communicating with sector officers and hospitals in order to manage the transport of patients to hospitals from the scene of the disaster.

Treatment Sector Officer - The individual that is responsible for overseeing activities conducted within the patient collection station. These activities will include ensuring that an adequate amount of equipment and personnel are present to provide both basic and advanced care.

Treatment Team Personnel - Individuals responsible for treatment of patients in priority treatment areas, as assigned to by the Treatment Sector Officer.

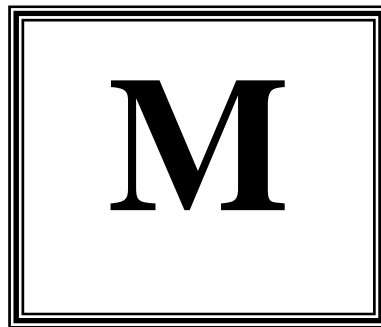
Triage - Sorting or categorizing victims of a disaster into priority categories based on the severity of injuries.

Triage Sector Officer - The individual that is responsible for overseeing triage at a disaster scene. This individual is also responsible for the establishment and maintenance of a triage team(s).

Triage Team Personnel - Individuals that are responsible for assisting in the initial triage evaluation and priority designation of victims of a mass casualty incident, as assigned by the Triage Sector Officer..

Unified Command Structure - A structure that allows for all agencies with jurisdictional responsibility to contribute to the planning, strategy, objectives and mitigation of a disaster.

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**References &
Acknowledgements**

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Model Procedures Guide for Emergency Medical Incidents; National Fire Service Incident Management Consortium, 1996.

“Emergency Medical Action Plan”; New York City Emergency Medical Service, 1987.

“Emergency Incident Rehabilitation, FA-114”, Federal Emergency Management Agency - United States Fire Administration, 1992.

Montgomery County Emergency Medical Services Disaster Operating Guidelines

Eastern PA EMS Region – Disaster Guidelines

Pennsylvania Department of Health – EMS Threat Level Guidelines

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Bucks County Emergency Health Services Office
Bucks County Department of Communications
Bucks County Emergency Health Services Council
Bucks County EMA Office

Bucks County Public Safety Training Center

Bucks County EMS Chiefs Association

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